EXHIBIT 30



Georgia Department of Behavioral Health & Developmental Disabilities

PROVIDER MANUAL

FOR

COMMUNITY BEHAVIORAL HEALTH PROVIDERS

FOR

THE DEPARTMENT OF BEHAVIORAL HEALTH & DEVELOPMENTAL DISABILITIES

FISCAL YEAR 2023
QUARTER 3

Effective Dates: January 1, 2023 through March 31, 2023

(Posted: December 1, 2022)

This FY 2023 Provider Manual is designed as an addendum to your contract/agreement with DBHDD to provide structure for supporting and serving individuals residing in the state of Georgia. DBHDD publishes its expectations, requirements, and standards for community Behavioral Health providers via policies and the Community Behavioral Health Provider Manual. The Community Behavioral Health Provider Manual is updated quarterly throughout each state fiscal year and is posted one month prior to the effective date. Community Behavioral Health Provider Manuals from previous fiscal years and quarters are archived on DBHDD's website at: http://dbhdd.georgia.gov/provider-manuals-archive.

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SUMMARY OF CHANGES TABLE

UPDATED FOR JANUARY 1, 2023 EFFECTIVE DATE (POSTED DECEMBER 1, 2022)

As a courtesy for Providers, this Summary of Changes is designed to guide the review of new and revised content contained in this updated version of the Provider Manual. The responsibility for thorough review of the Provider Manual content remains with the Provider.

Item #	Topic	Location	Summary of Changes
<u>-</u>	Crisis Intervention (C&A and Adult)	Part I, Section III. Service Definitions	In the Code Detail section, the "add-on each additional 30 mins" language was inadvertently missing from Practitioner Level 1, In-Clinic. It is now added.
2.	Assisted Outpatient Treatment Program	Part I, Section III. Service Definitions	A new service is added.
3.	Co-Responder Program	Part I, Section III. Service Definitions	A new service is added.
4.	CRRI	Part I, Section III. Service Definitions	Significant refinements to the entire Service Definition, and reorganization/clarification of previous content.
5.	CRR III	Part I, Section III. Service Definitions	Significant refinements to the entire Service Definition, and reorganization/clarification of previous content.
6.	Approved BH Practitioners Table	Part II, Section II. Staffing Requirements, Approved BH Practitioners Table	CPS-Parent and CPS-Youth were inadvertently missing from the table. They are now added.
			Reorganization and clarification of requirements for paper versus electronic records, as follows:
7.	Documentation Requirements	Part II, Section III. Documentation Requirements, 1.	A. Documentation/information in the medical record: Reorganized and clarified requirements.
		Overview or Documentation	 E. Added a new section: "Special Requirements for Paper versus Electronic Health Records/Medical Records." In the section: "For providers using Electronic Health Records (EHRs)/ Electronic Medical Records (EMRs)" added a new item d.
ωi	Documentation Requirements: DC-0 to 5 language	Part II, Section III. Documentation Requirements, 3. Diagnosis	New item F. Describes a tool and method that can assist practitioners in diagnosing children ages 4 through 5 years.

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m rd}$ Quarter Provider Manual for Community Behavioral Health Providers (January 1, 2023)

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		Part II, Section III: Documentation	New item # 4:
 ත්	Aggregated Claims	Requirements, 8. Progress Notes, C. Progress note documentation must address and adhere to the following: xii. Location of Intervention	Claims - In situations where multiple practitioners of the same U-level deliver a service (or services) for which the same procedure code and modifier(s) would be billed, but service delivery occurs at two different times, the time would need to be aggregated into one claim. If a different Place of Service code were applicable for each practitioner, only one should be selected and used on the aggregated claim.
10.	Glossary	Part IV: Appendices, Appendix A: Glossary of Terms	A definition of the DC 0-5™ Manual is added.

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ALL POLICIES ARE POSTED IN DBHDD POLICYSTAT LOCATED AT http://gadbhdd.policystat.com

Details are provided in the policy titled Access to DBHDD Policies for Community Providers, 04-100.

The <u>DBHDD PolicyStat INDEX</u> helps to identify policies applicable for Community Providers.

The New and Updated policies are listed below. For 90 days after the date of revision, users can see the track changes version of a policy

by scrolling to 'New and Recently Revised Policies' on the PolicyStat Home Page.

Questions or issues related to policy and service delivery should be directed to your Provider Relations

team: https://dbhddapps.dbhdd.ga.gov/PIMS/Default.aspx

Questions related to the Georgia Collaborative ASO functions such as those listed below can be directed to

GACollaborativePR@beaconhealthoptions.com

Provider Enrollment

· ASO Quality Reviews

Behavioral Health Registrations, Authorizations, and Billing for State Funded Services

Item#	Topic	Location	Summary of Changes
+	Suicide Prevention, Screening, Brief Intervention and Monitoring, 01-118	Part III General Policies and Procedures	REVISED: https://gadbhdd.policystat.com/policy/12323466/latest
2.	Suicide Prevention, Screening, Brief Intervention and Monitoring for Tier 2 and Tier 2+ Providers, 01-126	Part III General Policies and Procedures	REVISED: https://gadbhdd.policystat.com/policy/12324504/latest

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Georgia Department of Behavioral Health and Developmental Disabilities

January 1, 2023

PART I

Eligibility, Service Definitions and Service Requirements

Provider Manual for Community Behavioral Health Providers

Fiscal Year 2023

SECTION

ELIGIBILITY OF INDIVIDUALS SERVED DBHDD CRITERIA FOR MENTAL HEALTH AND ADDICTIVE DISEASE-SERVICES

A. ACCESS
CHILD & ADOLESCENT ADDLESCENT ADDLESCENT
Many adults/youth/families approach the state service delivery system looking for help. Not everyone who seeks assistance is in need of mental health or addictive
disease services. In order to efficiently and expeditiously address the needs of those seeking assistance, a quick assessment of the presenting circumstances is
warranted. A brief screening/assessment should be initiated by all community-based service providers on all individuals who present for services or who are referred b
the Georgia Crisis and Access Line (GCAL) for an evaluation. For the purposes of this definition, a brief screening/assessment refers to a rapid determination of an
adult/youth's need for services and whether there are sufficient indications of a mental illness and/or substance related disorder to warrant further evaluation and
admission to services.

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- 1. If the adult/youth does not have sufficient indications of a mental illness and/or substance related disorder, or if the individual does not appear to meet this eligibility criteria for services, then an appropriate referral to other services or agencies is provided.
- begin in Non-Intensive Outpatient services or may enroll in clinically appropriate intensive and/or specialized recovery/treatment services determined as a part of a 2. If the adult/youth does appear to have a mental illness and/or substance related disorder, and does appear to meet eligibility criteria, then the individual may either more comprehensive assessment process.

B. CORE CUSTOMER CLASSIFICATION AND ELIGIBILITY DETERMINATION

Eligibility for an individual is verified through the ASO system. The provider submits individual registration details on behalf of an individual. When it is determined that the individual qualifies for one of the DBHDD fund sources, then subsequent authorization can be requested.

This individual would be registered in the SHORT-TERM/IMMEDIATE registration category which will allow the agency up to seven (7) days of eligibility for the individual In the event that an individual presents for service and the agency is unable to ascertain identifying information, the individual may be engaged in some limited service without this identifying information, temporarily, with the expectation that the agency is working with the individual to acquire that information for continued enrollment. without additional unique identifying information. The following are potential services when utilizing this eligibility category and requesting authorization:

Community-based Inpatient Psychiatric/ Detoxification	Psychological Testing	Medication Administration
Residential Detoxification	Diagnostic Assessment	Community Support
Crisis Stabilization Unit	Interactive Complexity	Psychosocial Rehabilitation-Individual
Crisis Service Center	Crisis Intervention	Case Management
Temporary Observation	Psychiatric Treatment	Addictive Diseases Support Services
Behavioral Health Assessment/Service Plan Dev	Nursing Assessment and Care	Individual Outpatient
Peer Support (Individual and Whole Health)	Family Outpatient	Group Outpatient

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CHILD & ADDLESCENI	ADULI
There are four (4) variables for consideration to determine whether a youth qualifies	There are four (4) variables for consideration to determine whether an individual
as eligible for child and adolescent mental health and addictive disease services.	qualifies as eligible for adult mental health and addictive disease services.
1. Age: A youth must be under the age of 18 years old. Youth aged 18-21 years	1. Age: An individual must be over the age of 18 years old, to include the older
children still in high school or when it is otherwise developmentally/clinically	adult population 65+ years old. Individuals under age 18 may be served in adult
indicated) may be served to assist with transitioning to adult services.	services if they are emancipated minors under Georgia Law, and if adult services
2. Diagnostic Evaluation: The DBHDD system utilizes the Diagnostic and Statistical	are otherwise clinically/developmentally indicated.
Manual of Mental Disorders (DSM) classification system to identify, evaluate and	2. Diagnostic Evaluation: The DBHDD system utilizes the Diagnostic and
classify a youth's type, severity, frequency, duration and recurrence of symptoms.	Statistical Manual of Mental Disorders (DSM) classification system to identify,
The diagnostic evaluation must yield information that supports an emotional	evaluate and classify an individual's type, severity, frequency, duration and
disturbance and/or substance related diagnosis (or diagnostic impression). The	recurrence of symptoms. The diagnostic evaluation must yield information that
diagnostic evaluation must be documented adequately to support the diagnosis.	supports a psychiatric disorder and/or substance related diagnosis (or diagnostic
5. Functional/Risk Assessment: Information gathered to evaluate a	Impression). The diagnostic evaluation must be documented adequately to
chind/addressents ability to idificially cope on a day-to-day basis comprises the functional/risk assessment. This includes voluth and family resource utilization and	support the diagnostic impression/diagnosis. 3. Functional/Risk Assessment: Information gathered to evaluate an individual's
the volith's role performance, social and behavioral skills, cognitive skills.	ability to function and cone on a day-to-day basis comprises the functional/risk
communication skills, personal strengths and adaptive skills, needs and risks as	assessment. This includes the individual's resource utilization, role performance.
related to an emotional disturbance substance related disorder or co-occurring	social and behavioral skills, cognitive skills, communication skills, independent
disorder. The functional/risk assessment must vield information that supports a	living skills, personal strengths and adaptive skills, needs and risks as related to a
behavioral health diagnosis (or diagnostic impression) in accordance with the DSM.	psychiatric disorder, substance related disorder or co-occurring disorder. The
4. Financial Eligibility: Please see Payment by Individuals for Community	functional/risk assessment must yield information that supports a behavioral
Behavioral Health Services, 01-107.	health diagnosis (or diagnostic impression) in accordance with the DSM.
	t. Financial Eligibility: Please see Payment by Individuals for Community
	Behavioral Health Services, 01-107.
C. PRIORITY FOR SERVICES	
CHILD & ADOLESCENT	ADULT
The following youth are priority for services:	The following individuals are the priority for ongoing support services:
1. The first priority group for services is Youth:	1. The first priority group for services is individuals currently in a state operated
☐ Who are at risk of out-of-home placements; and	psychiatric facility (including forensic individuals), state funded/paid inpatient
☐ Who are currently in a psychiatric facility or a community-based crisis residential	services, a crisis stabilization unit or crisis residential program.
service including a crisis stabilization unit.	Page socional priority described as a socional priority described
2 The second priority aroun for services is:	2. The second phonic group for services is □ Individuals with a history of one or more hospital admissions for psychiatric/□
The decorate priority group for early each pospital admissions for	
psychiatric/substance use disorder reasons within the past 3 years:	on unit admissions
☐ Youth with a history of one or more crisis stabilization unit admissions within the	within the past 3 years;
past 3 years;	☐ Individuals with a history of enrollment on an Assertive Community
	Treatment team within the past 3 years;

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 Individuals with court orders to receive services (especially related to restoring competency); Individuals under the correctional community supervision with mental illness or conference. 	Individuals released from secure custody (county/city jails, state prisons, diversion programs, forensic inpatient units) with mental illness or substance use disorder or dependence; ☐ Individuals aging out of out of home placements or who are transitioning from intensive C&A services, for whom adult services are clinically and developmentally appropriate; ☐ Pregnant women; ☐ Individuals who are homeless; or,	"	Specific to AD Women's Services, Providers shall give preference to admission to services as follows: 1) Pregnant women who are using drugs by means of intravenous injection; 2) Pregnant women who have substance use disorders, but who are not using drugs by means of intravenous injection; 3) Non-pregnant women who are using drugs by means of intravenous injection; and then 4) All others.	sign. In many cases, the electronic ASO system provides for an automated process information provided to the ASO. Periodically, a provider will be asked to provide (P).	tion from the ASO via provider batch submission or via the ASO Connect system, some services will have specific requirements identified in the Reporting and Billing Requirements section of the unique	
 Youth with a history of enrollment on an Intensive Family Intervention team within the past 3 years; Youth with court orders to receive services; 	substance use disorder or dependence; substance use disorder or dependence; Youth released from secure custody (county/city jails, state YDCs/RYDCs, diversion programs, forensic inpatient units) with mental illness or substance use disorder or dependence; Pregnant youth; Youth who are homeless; or, IV drug users.	contract/agreement with the DBHDD.	REDVICES ALITHODIZATION	Services are authorized based on individualized need considered alongside service design. In many cases, the electronic ASO system provides for an automated process to request services and to receive authorization based upon clinical and demographic information provided to the ASO. Periodically, a provider will be asked to provide additional supporting information to the ASO, e.g., an Individualized Recovery Plan (IRP).		

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E. APPROVED DIAGNOSES

Section II of this manual will require a diagnosis which is within that category of condition. (e.g., Alcohol Intoxication with Use Disorder [F10.229] would be an acceptable Please reference the table in Appendix B of this document for approved authorization diagnoses. The diagnoses listed in Appendix B are ICD-10 diagnosis which are organized here into Mental Health (MH) and Substance Use (SU) categories. Services that are uniquely identified as being MH only or SU only on the chart in Part 1, diagnosis for receiving Ambulatory Detox [SU])

Disorder and any associated psychiatric symptoms and/or substance use. Individuals with a Neurocognitive Disorder must demonstrate a cognitive ability to participate in, diagnosis and may now be showing signs of a Neurocognitive Disorder such as Dementia or Alzheimer's Disease should remain included in treatment until such time as An individual diagnosed with a Neurocognitive Disorder must have a documented history of a qualifying behavioral health diagnosis that pre-dates the Neurocognitive and benefit from the behavioral health service(s) in which they are enrolled. Individuals who have historically received treatment for a qualifying behavioral health the individual is no longer capable of active participation in treatment services and supports.

circumstances, that there may be an exception to this rule. In this event, the ASO would do a review of such things as a recent physical examination, unique provider skill Diagnosis Exceptions: Several diagnostic codes may have an E identified. This indicates that the DBHDD does not cover this diagnosis code, but that in certain specialties, proposed IRPs, etc. to determine whether or not authorization will be granted.

diagnose individuals and report the ICD-10 code accordingly. Note that, due to the adjustment of diagnoses between DSM IV and DSM V, not all ICD-9 codes will have a Appendix B only includes ICD-10 diagnosis codes that correspond with an applicable DSM V code. As noted in Part II of this manual, providers should use DSM V to valid match to an ICD-10 code. Providers should use the DSM V as the initial source to determine the appropriate ICD-10 codes for authorization requests

typically results in a more complicated clinical presentation. Individuals diagnosed with the excluded mental disorders listed may receive services ONLY when these disorders co-occur with a qualifying mental illness or substance related disorder. The qualifying mental illness or substance related disorder must be the presenting NOTE: The presence of co-occurring mental illnesses/emotional disturbances, substance related disorders and/or developmental disabilities is not uncommon and problem and the focus of service, and the individual must meet the functional criteria listed above.

SECTION II

ORIENTATION TO SERVICE AUTHORIZATION

FY2023 Behavioral Health Levels of Service

Specifically related to DBHDD authorization through its ASO vendor, services are organized into a set of categories which are defined by Level of Care, then Type of Care, which then define a subset of services.

FY2023 Behavioral Health Services

Level of Service: Inpatient & Higher Level of Care (HLOC)

					I			I		
	Place of Service	21, 51	21, 51	11, 52, 53, 55, 56, 99	11, 52, 53, 55, 56, 99	11, 52, 53, 55, 56, 99	11, 52, 53, 55, 56, 99	11, 52, 53, 55, 56, 99	56	11, 12, 53, 99
	Max Daily Units	1	1	Н	1	Н	1	1	1	1
nt Auth	Max Units Auth'd	varies	varies	varies	varies	varies	varies	varies	30	varies
Concurrent Auth	Max Auth Length	varies	varies	varies	varies	varies	varies	varies	30	varies
Auth	Max Units Auth'd	varies	varies	10	10	10	10	30	30	20
Initial Auth	Max Auth Length	varies	varies	10	10	10	10	30	30	20
	Service Description	Community Based Inpatient (Psych)	Community Based Inpatient (Detox)	Crisis Stabilization - Adult	Crisis Stabilization - Adult	Crisis Stabilization - C&A	Crisis Stabilization - C&A	Crisis Stabilization - C&A ASD	PRTF	Residential Detox
Service	Groups Available	20102	20102	20101	20101	20101	20101	20110	20506	21101
Service	Code	IPF	IPF	CUA	CUA	CUC	CNC	CAU	PRT	IDF
	Type of Care Description	Behavioral	Detox	Behavioral	Detox	Behavioral	Detox	Behavioral	Behavioral	Detox
Type of	Code	ВЕН	DETOX	ВЕН	DETOX	ВЕН	DETOX	ВЕН	ВЕН	DETOX
Тупр	of of Service	MH, MHSU	NS	MH, MHSU	SU	MH, MHSU	SU	QQ	МН	ns
laval	of Service	Inpt	Inpt	Inpt	Inpt	Inpt	Inpt	Inpt	Inpt	Inpt

Level of Service: Outpatient

	Place of Service			11, 12, 53, 99	11, 12, 53, 99
	Max	Daily	Units	09	12
nt Auth	Max	Units	Auth'd	240	50
Concurrent Auth	Max	Auth	Length	06	06
Initial Auth	Max	Units	Auth'd	240	20
Initial	Max	Auth	Length	06	06
	Service Description			Assertive Community Treatment	Community Transition Planning
Service	Groups	Available		20601	21202
Service	Class	Code		ACT	CT1
	Type of Care Description			ACT	
Type of	Care	Code		ACT	
Тупр	of	Service		Outpt MH,	
layal		_			

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	Place of Service	11, 12, 53, 99	11, 12, 53, 99	11, 12, 53, 99	11, 12, 53, 99	11, 12, 53, 99	11, 12, 53, 99	11, 12, 53, 99	11, 12, 53, 99	11, 12, 53, 99	11, 52, 53, 55, 56, 99	11, 52, 53, 55, 56, 99	11, 12, 53, 99	11, 12, 53, 99	11, 12, 53, 99	11, 12, 53, 99	11, 12, 53, 99	11, 12, 53, 99	11, 12, 53, 99	11, 12, 53, 99	11, 12, 53, 99	11, 12, 53, 99	11, 12, 53, 99	11, 12, 53, 99	11, 12, 53, 99	11, 12, 53, 99	11, 12, 53, 99	11, 12, 53, 99	11, 12, 53, 99	11, 12, 53, 99
	Max Daily	24	24	2	4	2	16	1	4	16	1	1	24	2	4	∞	2	2	1	32	8	16	1	4	4	12	8	8	09	12
nt Auth	Max Units Auth'd	varies	varies	varies	varies	varies	varies	varies	varies	varies	7	7	32	2	22	80	40	80	24	32	32	24	14	80	20	84	80	80	240	50
Concurrent Auth	Max Auth	varies	varies	varies	varies	varies	varies	varies	varies	varies	20	20	20	20	20	20	20	20	20	20	20	20	20	20	20	20	20	20	06	06
Auth	Max Units	32	32	2	22	40	24	8	80	32	7	7	32	2	22	80	40	80	24	32	32	24	14	80	20	84	80	80	240	20
Initial Auth	Max Auth	14	14	14	14	14	14	14	14	14	20	20	20	20	20	20	20	20	20	20	20	20	20	20	20	20	20	20	06	06
	Service Description	Ambulatory Detox	BH Assmt & Service Plan Development	Diagnostic Assessment	Interactive Complexity	Psychiatric Treatment - (E&M)	Addictive Disease Support Services	Individual Outpatient Services	Group Outpatient Services	Family Outpatient Services	Crisis Service Center	Temporary Observation	BH Assmt & Service Plan Development	Diagnostic Assessment	Interactive Complexity	Crisis Intervention	Psychiatric Treatment - (E&M)	Nursing Services	Medication Administration	Community Support - Individual	Psychosocial Rehabilitation - Individual	Addictive Disease Support Services	Individual Outpatient Services	Group Outpatient Services	Family Outpatient Services	Case Management	Peer Support - Adult - Individual	Community Transition Planning	Community Support Team	Community Transition Planning
Service	Groups Available	21102	10101	10103	10104	10120	10152	10160	10170	10180	20103	20105	10101	10103	10104	10110	10120	10131	10140	10150	10151	10152	10160	10170	10180	21302	20306	21202	20605	21202
Service	Code	OPD	ВНА	DAS	CAO	PEM	ADS	NIT.	GRP	FAM	CSC	UHB	ВНА	DAS	CAO	CIN	PEM	NRS	MED	CSI	PSR	ADS	NIT.	GRP	FAM	CMS	PSI	CT1	CST	CT1
	Type of Care Description	AMBULATORY DETOX									CRISIS SERVICES																		CST	
,	Type of Care Code	AMBDTX									CS	_	_								_								CST	
Tvne	of Service	SU		_		_					MH,	SU,	2																МН	
Level	of Service	Outpt									Outpt																		Outpt	

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				Cas	e 1:1	L6-c\	/-03	-880	ELR		000	cu	me	ent 4	48	3-7	'3		Fil	ed	11	./2	9/2	23		Pa	ge	16	of	62
	Place of Service		11, 12, 14, 53, 55, 56, 99	11, 12, 14, 53, 55, 56, 99	11, 12, 14, 53, 55, 56, 99	11, 12, 14, 53, 55, 56, 99	11, 12, 14, 53, 55, 56, 99	11, 12, 14, 53, 55, 56, 99	11, 12, 14, 53, 55, 56, 99	11, 12, 14, 53, 55, 56, 99	11, 12, 53, 99	11, 12, 53, 99	11, 12, 53, 99	11, 12, 53, 99	11, 12, 53, 99	11, 12, 53, 99	11, 12, 53, 99	11, 12, 53, 99	11, 12, 53, 99	11, 12, 53, 99	11, 12, 53, 99	11, 12, 53, 99	11, 12, 53, 99	11, 12, 53, 99	11, 12, 53, 99	11, 12, 53, 99	11, 12, 53, 99	11, 12, 53, 99	11, 12, 53, 99	11, 12, 53, 99
	Max Daily	Units	1	1	1	1	1	1	∞	1	24	48	12	1/mo	16	8	16	see guidelines	24	4	48	12	5	24	2	4	2	16	1	12
ent Auth	Max Units	Auth'd	14	06	06	06	06	90	26	180	104	104	100	3	24	12	24	see guidelines	24	12	288	50	320	32	4	48	12	48	9	50
Concurrent Auth	Max Auth	Length	14	06	06	06	06	06	180	180	06	06	06	06	06	06	06	06	06	90	06	06	180	180	180	180	180	180	180	180
Auth	Max Units	Auth'd	30	06	06	06	06	06	13	180	104	104	100	3	24	12	24	see guidelines	24	12	288	50	320	32	4	48	12	48	9	50
Initial Auth	Max Auth	Length	30	06	06	06	06	06	06	180	06	90	90	06	90	90	90	06	90	90	06	90	180	180	180	180	180	180	180	180
	Service Description		Crisis Respite Apartment	Residential Services (Independent)	Residential Services (CRR Level 3)	Residential Services (Semi- Independent)	Residential Services (CRR Level 1)	Residential Services (Intensive)	Community Residential Rehabilitation 4	Structured Residential - C&A	Intensive Case Management	Psychosocial Rehabilitation - Individual	Community Transition Planning	Intensive Customized Care Coordination	Behavioral Assistance	Clinical Consultative Services	Expressive Clinical Services	Customized Goods and Services	Respite Services	Transportation Services	Intensive Family Intervention	Community Transition Planning	SAIOP - Adult	BH Assmt & Service Plan Development	Diagnostic Assessment	Interactive Complexity	Psychiatric Treatment - (E&M)	Nursing Services	Medication Administration	Community Transition Planning
Contract	Groups Available		20104	20501	20502	20502	20503	20503	20514	20510	21301	10151	21202	21303	32101	32102	32103	32104	32105	32106	20902	21202	20606	10101	10103	10104	10120	10131	10140	21202
Coincid	Code		APT	IRS	SRS	SRS	LN	L	CL4	STR	ICM	PSR	CT1	IC3	BAS	CLC	EXP	CGD	RPT	TSP	IFI	CT1	IOA	ВНА	DAS	CAO	PEM	NRS	MED	CT1
	Type of Care Description		Crisis Apartment	Residential Services (Independent)	Residential Services (CRR Level 3)	Residential Services (Semi-Independent)	Residential Services (CRR Level 1)	Residential Services (Intensive)	Community Residential Rehab 4	Structured Residential - C&A	ICM			Intensive Customized Care	Coordination						Intensive Family	Intervention	SAIOP - Adult							
T	Care		CA	IR	SIM	SIM	INR	INR	CR4	SRC	ICM			וכככ				_			IFI		SAIOPA	_	_					
, T	of Service		Ψ	MH, SU	ΗW	SU	ΗW	SU	Η	MH, SU	МН			НМ							МΗ		SU							
	Level of Service		Outpt	Outpt	Outpt	Outpt	Outpt	Outpt	Outpt	Outpt	Outpt			Outpt							Outpt		Outpt							

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Case 1:16-cv-03088-ELR	Document 448-73	Filed 11/29/23	Page 17 of 627
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							Initial Auth	Auth	Concurrent Auth	ant Auth		
l evel of	Туре	Type of	Type of Care	Service	Service							
Service	of	Care	Description	Class	Groups	Service Description	Max Auth	Max Units	Auth	Max Units	Max Daily	Place of Service
				C045			Length	Auth'd	Length	Auth'd	Units	
Outpt	NS	SAIOPC	SAIOP - C&A	100	20907	SAIOP - C&A	180	320	180	320	5	11, 12, 53, 99
				ВНА	10101	BH Assmt & Service Plan Development	180	32	180	32	24	11, 12, 53, 99
				DAS	10103	Diagnostic Assessment	180	4	180	4	2	11, 12, 53, 99
				CAO	10104	Interactive Complexity	180	48	180	48	4	11, 12, 53, 99
				PEM	10120	Psychiatric Treatment - (E&M)	180	12	180	12	2	11, 12, 53, 99
				NRS	10131	Nursing Services	180	48	180	48	16	11, 12, 53, 99
				CT1	21202	Community Transition Planning	180	50	180	50	12	11, 12, 53, 99
Outpt	MH,	OIN	Non-Intensive	ВНА	10101	BH Assmt & Service Plan Development	06	32	275	64	24	11, 12, 53, 99
	SU,		Outpatient	TES	10105	Psychological Testing	06	10	275	10	5	11, 12, 53, 99
	2			DAS	10103	Diagnostic Assessment	06	2	275	4	2	11, 12, 53, 99
				CAO	10104	Interactive Complexity	06	24	275	96	4	11, 12, 53, 99
				CIN	10110	Crisis Intervention	06	20	275	96	16	11, 12, 53, 99
				PEM	10120	Psychiatric Treatment - (E&M)	06	12	275	48	2	11, 12, 53, 99
				NRS	10131	Nursing Services	06	12	275	120	16	11, 12, 53, 99
				MED	10140	Medication Administration	06	9	275	120	1	11, 12, 53, 99
				CSI	10150	Community Support - Individual	06	89	275	160	48	11, 12, 53, 99
				PSR	10151	Psychosocial Rehabilitation - Individual	90	52	275	160	48	11, 12, 53, 99
				ADS	10152	Addictive Disease Support Services	06	100	275	009	48	11, 12, 53, 99
				NIT	10160	Individual Outpatient Services	06	8	275	48	2	11, 12, 53, 99
				GRP	10170	Group Outpatient Services	06	480	275	400	20	11, 12, 53, 99
				FAM	10180	Family Outpatient Services	06	32	275	120	16	11, 12, 53, 99
				CT1	21202	Community Transition Planning	06	24	275	48	24	11, 12, 53, 99
				CMS	21302	Case Management	06	89	275	160	24	11, 12, 53, 99
				PSI	20306	Peer Support - Adult - Individual	06	72	275	312	48	11, 12, 53, 99
				PSW	20302	Peer Support Whole Health & Wellness	06	72	275	312	9	11, 12, 53, 99
				YPI	20308	Youth Peer Support - Individual	06	72	275	312	24	11, 12, 53, 99
				YPG	20309	Youth Peer Support - Group	90	162	275	486	5	11, 12, 53, 99
				PPI	20310	Parent Peer Support - Individual	90	72	275	312	24	11, 12, 53, 99
				PPG	20311	Parent Peer Support - Group	06	162	275	486	5	11, 12, 53, 99

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	Place of Service			11, 12, 53, 99	11, 12, 53, 99	11, 12, 53, 99	11, 12, 53, 99	11, 12, 53, 99	11, 12, 53, 99	11, 12, 53, 99	11, 12, 53, 99	11, 12, 53, 99		11, 12, 53, 99	11, 12, 53, 99	11, 12, 53, 99	11, 12, 53, 99	11, 12, 53, 99	11, 12, 53, 99	11, 12, 53, 99	11, 12, 53, 99	11, 12, 53, 99	11, 12, 53, 99	11, 12, 53, 99	11, 12, 53, 99	11, 12, 18, 53, 99	11, 12, 53, 99	11, 12, 53, 99	11, 12, 53, 99	11, 12, 53, 99	11, 12, 53, 99	11, 12, 53, 99	11, 12, 53, 99	11, 12, 53, 99	11, 12, 53, 99	11, 12, 53, 99	11, 12, 53, 99	11, 12, 53, 99	11, 12, 53, 99	11, 12, 53, 99	11, 12, 53, 99
	Max	Daily	Units	1	12	2	4	16	1	4	1	4	1	4	4	4	48	2	9	24	2	24	2	48	20	1	8	24	2	2	4	2	16	1	48	2	20	16	24	48	9
ent Auth	Max	Units	Auth'd	150	24	4	96	96	9	96	150	96	36	730	48	48	520	650	400	312	486	312	486	104	300	3	150	32	5	2	48	24	9	09	300	24	200	09	24	312	312
Concurrent Auth	Max	Auth	Length	365	365	365	365	365	365	365	365	365	365	365	365	365	180	180	180	275	275	275	275	180	180	90	06	365	365	365	365	365	365	365	365	365	365	365	365	365	365
Auth	Max	Units	Auth'd	80	24	2	24	20	9	24	80	100	12	180	48	48	520	650	400	72	162	72	162	104	300	3	150	32	5	2	48	24	09	09	300	24	200	09	24	312	312
Initial Auth	Max	Auth	Length	90	06	06	06	06	90	06	90	90	90	90	90	06	180	180	180	90	90	90	06	180	180	90	06	365	365	365	365	365	365	365	365	365	365	365	365	365	365
	Service Description			Opioid Maintenance	BH Assmt & Service Plan Development	Diagnostic Assessment	Interactive Complexity	Crisis Intervention	Psychiatric Treatment - (E&M)	Nursing Services	Medication Administration	Addictive Disease Support Services	Individual Outpatient Services	Group Outpatient Services	Family Outpatient Services	Peer Support – Adult - Individual	Peer Support - Adult - Individual	Peer Support - Adult - Group	Peer Support Whole Health & Wellness	Youth Peer Support - Individual	Youth Peer Support - Group	Parent Peer Support - Individual	Parent Peer Support - Group	Psychosocial Rehabilitation - Individual	Psychosocial Rehabilitation - Group	Supported Employment	Task Oriented Rehabilitation	BH Assmt & Service Plan Development	Diagnostic Assessment	Interactive Complexity	Crisis Intervention	Psychiatric Treatment - (E&M)	Nursing Services	Medication Administration	Addictive Disease Support Services	Individual Outpatient Services	Group Outpatient Services	Family Outpatient Services	Community Transition Planning	Peer Support - Adult - Individual	Peer Support Whole Health & Wellness
Corvico	Groups	Available		21001	10101	10103	10104	10110	10120	10131	10140	10152	10160	10170	10180	20306	20306	20307	20302	20308	20309	20310	20311	10151	20908	20401	20402	10101	10103	10104	10110	10120	10131	10140	10152	10160	10170	10180	21202	20306	20302
Corvice	Class	Code		MDM	BHA	DAS	CAO	CIN	PEM	NRS	MED	ADS	ZIL	GRP	FAM	PSI	PSI	PSP	PSW	YPI	YPG	PPI	PPG	PSR	PRE	SE8	TOR	ВНА	DAS	CAO	CIN	PEM	NRS	MED	ADS	NIL	GRP	FAM	CT1	PSI	PSW
	Type of Care	Description		Medication Assisted	Treatment (MAT)												Peer Support	Program		C&A Peer Supports				Psychosocial Rehab	Program	Supported	Employment	Treatment Court -	AD												
Type of	Care	Code		MO													PSP			PSC				PRP		SE		TCSAD													
- Cay	of d	Service		SU													MH,	SU,	MHSU	MH,	SU,	MHSU		МН		МΗ		SU													
	Level of	Service		Outpt													Outpt			Outpt				Outpt		Outpt		Outpt													

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			С	as	se	1::	16-	-cv	-03	308	38-	EL	R	I	Οo	cui	me	nt	44	18-	73	3	Fi	iled	1 1	1/2	9/2	23		Pa	ıge	e 1	9	of	62	7	
	Place of Service		11, 12, 53, 99	11, 12, 53, 99	11, 12, 53, 99	11, 12, 53, 99	11, 12, 53, 99	11, 12, 53, 99	11, 12, 53, 99	11, 12, 53, 99	11, 12, 53, 99	11, 12, 53, 99	11, 12, 53, 99	11, 12, 53, 99	11, 12, 53, 99	11, 12, 53, 99	11, 12, 53, 99	11, 12, 53, 99	11, 12, 53, 99	11, 12, 53, 99	11, 12, 53, 99	11, 12, 53, 99	11, 12, 53, 99	11, 12, 53, 99	11, 12, 53, 99	11, 12, 53, 99	11, 12, 14, 53, 55, 56, 99	11, 12, 53, 99	11, 12, 53, 99	11, 12, 53, 99	11, 12, 53, 99	11, 12, 53, 99	11, 12, 53, 99	11, 12, 53, 99	11, 12, 53, 99	11, 12, 14, 53, 55, 56, 99	11, 12, 14, 53, 55, 56, 99
	Max	Daily Units	24	2	2	4	2	16	1	48	2	20	16	24	24	48	9	24	2	4	2	16	48	1	20	8	1	48	9	24	2	4	2	16	1	1	1
nt Auth	Max	Units Auth'd	32	5	2	48	24	09	09	80	24	200	09	24	80	312	312	32	4	48	12	48	200	36	1,170	100	180	156	156	32	4	48	24	48	40	180	180
Concurrent Auth	Max	Auth Length	365	365	365	365	365	365	365	365	365	365	365	365	365	365	365	180	180	180	180	180	180	180	180	180	180	180	180	180	180	180	180	180	180	180	180
Auth	Max	Units Auth'd	32	5	2	48	24	09	09	80	24	200	09	24	80	312	312	32	4	48	12	48	200	36	1,170	100	180	156	156	32	4	48	24	48	40	180	180
Initial Auth	Max	Auth Length	365	365	365	365	365	365	365	365	365	365	365	365	365	365	365	180	180	180	180	180	180	180	180	180	180	180	180	180	180	180	180	180	180	180	180
	Service Description		BH Assmt & Service Plan Development	Diagnostic Assessment	Interactive Complexity	Crisis Intervention	Psychiatric Treatment - (E&M)	Nursing Services	Medication Administration	Psychosocial Rehabilitation - Individual	Individual Outpatient Services	Group Outpatient Services	Family Outpatient Services	Community Transition Planning	Case Management	Peer Support - Adult - Individual	Peer Support Whole Health & Wellness	BH Assmt & Service Plan Development	Diagnostic Assessment	Interactive Complexity	Psychiatric Treatment - (E&M)	Nursing Services	Addictive Disease Support Services	Individual Outpatient Services	Group Outpatient Services	Family Outpatient Services	WTRS - Transitional Bed	Peer Support - Adult - Individual	Peer Support Whole Health & Wellness	BH Assmt & Service Plan Development	Diagnostic Assessment	Interactive Complexity	Psychiatric Treatment - (E&M)	Nursing Services	Medication Administration	WTRS - Residential	WTRS - Transitional Bed
3	Groups	Available	10101	10103	10104	10110	10120	10131	10140	10151	10160	10170	10180	21202	21302	20306	20302	10101	10103	10104	10120	10131	10152	10160	10170	10180	20517	20306	20302	10101	10103	10104	10120	10131	10140	20516	20517
0	Class	Code	BHA	DAS	CAO	CIN	MEM	NRS	MED	PSR	NIT	GRP	FAM	CT1	CMS	ISd	MSd	ВНА	DAS	CAO	PEM	NRS	ADS	NIL	GRP	FAM	ШM	ISd	MSd	BHA	DAS	CAO	PEM	NRS	MED	WTR	WTT
	Type of Care Description		Treatment Court - MH															WTRS - Outpatient												WTRS - Residential							
Tunne	Care	Code	TCS															WTRSO												WTRSR							
Ė	of	Service	МН															SU												SU							
	Jo	Service	Outpt															Outpt												Outpt							

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Auth Length Auth'd Le	Service Service	Service	Service	Service		Constitution O	Initial Auth	Auth	Concurrent Auth	nt Auth Max	×eV	وة بيري عمر ورواه
See See See See note¹ note¹ note¹ note¹ 180 140 24 180 520 180 520 48 180 300 180 48 8 180 100 180 48 16 180 64 180 64 16 180 32 180 32 24 180 36 36 8	of Care Type of Care Description Class Groups Service Code Available	Type of Care Description Class Code	Code	Groups Available		Service Description	Auth Length	Units Auth'd	Auth Length	Units Auth'd	Daily Units	Place of Service
note¹ note¹ note¹ note¹ 180 140 180 140 24 180 520 180 520 48 180 300 180 48 8 180 100 180 48 8 180 64 16 48 16 180 32 180 32 24 180 36 36 8 8	HV Georgia Housing CHV 2051E	Georgia Housing	λHΟ	20515		Housing Volumes	See	See	See	See	See	Cop note1
180 140 180 140 24 180 520 180 520 48 180 300 180 48 8 180 100 180 48 18 180 64 16 16 16 180 32 180 32 24 180 36 180 36 8		À	À	CTC07		nousing voucilei	note ¹	סבב ווסוב				
180 520 180 520 48 180 300 180 48 8 180 100 180 48 18 180 64 180 64 16 180 32 180 32 24 180 36 8 8	HSUP	GHV Housing CMS	CMS	21302		Case Management	180	140	180	140	24	11, 12, 53, 99
180 300 180 300 48 180 100 180 48 8 180 64 180 64 16 180 32 180 32 24 180 36 180 36 8	MHSU Supports PSI 20306	PSI	PSI	20306		Peer Support – Adult - Individual	180	520	180	520	48	11, 12, 53, 99
180 100 180 48 180 64 180 64 16 180 32 24 24 180 36 180 36 8	PSR 10151			10151		Psychosocial Rehabilitation - Individual	180	300	180	300	48	11, 12, 53, 99
180 64 180 64 16 180 32 180 32 24 180 36 180 36 8	ADS 10152			10152		Addictive Disease Support Services	180	100	180	100	48	11, 12, 53, 99
180 32 180 32 24 180 36 180 36 8	CIN 10110			10110		Crisis Intervention	180	64	180	64	16	11, 12, 53, 99
180 36 180 36 8	CT1 21202			21202		Community Transition Planning	180	32	180	32	24	11, 12, 53, 99
	CL4 20514			20514	i	Community Residential Rehabilitation 4	180	36	180	36	∞	11, 12, 53, 99

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SERVICE DEFINITIONS **SECTION III**

Child and Adolescent Non-Intensive Outpatient Services

Behavioral F	Behavioral Health Assessment													
Transaction Code	Code Detail	Code	Mod 1	Mod N	Mod M	Mod Rate 4		Code Detail	Code	Mod 1	Mod 2	Mod N	Mod 4	Rate
	Practitioner Level 2, In-Clinic	H0031	U2	90		\$38.97		Practitioner Level 2, Out-of-Clinic	H0031	U2	U7		03	\$46.76
	Practitioner Level 3, In-Clinic	H0031	N3	90		\$30.01		Practitioner Level 3, Out-of-Clinic	H0031	N3	U2		93	\$36.68
	Practitioner Level 4, In-Clinic	H0031	N4	90		\$20.30		Practitioner Level 4, Out-of-Clinic	H0031	U4	U2		0)	\$24.36
MH Assessment	Practitioner Level 5, In-Clinic	H0031	N2	90		\$15.13		Practitioner Level 5, Out-of-Clinic	H0031	U5	U2		93	\$18.15
by a non-	Practitioner Level 2, Via						ш	Practitioner Level 4, Via interactive						
Physician	interactive audio and video	H0031	GT	N2		\$38.97		audio and video telecommunication	H0031	GT	U4		0)	\$20.30
,	telecommunication systems						S	systems						
	Practitioner Level 3, Via							Practitioner Level 5, Via interactive						
	interactive audio and video	H0031	CT	N3		\$30.01		d video telecommunication	H0031	ED .	02		99	\$15.13
	telecommunication systems						0)							
Unit Value	15 minutes						_	Utilization Criteria	TBD					
	The Behavioral Health Assessi perspective as a full partner an	ment proc d should i	sess con include	sists of a family/re	a face-to	o-face con le caregive	npreher er(s) an	The Behavioral Health Assessment process consists of a face-to-face comprehensive clinical assessment with the individual, which must include the youth's perspective as a full partner and should include family/responsible caregiver(s) and others significant in the youth's life as well as other involved agencies	lividual, w	which mu as other	ust incluc r involvec	de the your	th's	
	agencies/treatment providers.					o)		
	The mimose of the Behavioral Health Assessment	Health As	Jusses	יחל חירים	of si ss.	nather all	informs	process is to gather all information needed in to determine the voluth's problems symptoms strengths needs	th's probl	oms sv	motoms	strenaths	needs	
Service	abilities, resources and prefere	nces, to c	dolevet	a social	(extent o	of natural	hoddns	abilities, resources and preferences, to develop a social (extent of natural supports and community integration) and medical history, to determine functional level and	edical his	story, to	determir	ne function	al level	and
	degree of ability versus disabili	ty, if nece	ssary, t	o assess	trauma	history ar	nd statu	degree of ability versus disability, if necessary, to assess trauma history and status, and to engage with collateral contacts for other assessment information. An age-	tacts for c	other as:	sessmen	nt informati	on. An	age-
	sensitive suicide nsk assessment shall also be for/ruling-out potential co-occurring disorders.	ent shall a rring disor	also be c rders.	complete	d. Ine i	ntormatior	n gathei	sensitive suicide nsk assessment shall also be completed. The information gathered should support the determination of a differential diagnosis and assist in screening for/ruling-out potential co-occurring disorders.	otadiffe	rential (diagnosis	s and assis	st in scr	eening
	As indicated, information from	nedical, r	nursing,	school,	nutrition	al, etc. sta	aff shou	As indicated, information from medical, nursing, school, nutritional, etc. staff should serve as the basis for the comprehensive assessment and the resulting IRP.	nensive a	ıssessm	ent and	the resultii	ng IRP.	
Admission		ntal illnes	s or sub	stance-r	elated d	lisorder; a	puı							
Criteria	 Initial screening/intake information indicates a need for further assessment. 	ormation i	ndicates	s a need	TOT TUITE	ier assess	sment.							
Continuing Stay Criteria	The youth's situation/functioning has changed in such a way that previous assessments are outdated.	ig has cha	anged ir.	such a	way tha	t previous	assess	ments are outdated.						
Discharge	1. An adequate continuing care plan has been established; and one or more of the following:	ire plan h	as been	establis	hed; an	d one or	more o	f the following:						
Criteria	 Individual has withdrawn or been discharged from service; or Individual no longer demonstrates need for additional assessment 	ir been di: ustrates n	scharge	d trom s	ervice; (or sment								
Service	To promote access, providers r	may use	Telemed	licine as	a tool to	provide (direct in	To promote access, providers may use Telemedicine as a tool to provide direct interventions to individuals for whom English is not their first language. Examples of this include:	English is	not thei	ir first lar	ıguage. Ελ	amples	of this
(majooooo)														

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penaviorai	Пеап	Denavioral nealth Assessment
		 the use of one-to-one service intervention via Telemedicine, connecting the individual to a practitioner who speaks the individuals language versus use of interpreters: and/or
		 the use of an interpreter via Telemedicine to support the practitioner in delivering the identified service.
	Tele use con	Telemedicine may only be utilized when delivering this service to an individual for whom English is not their first language. The individual/family must consent to the use of this modality. This consent should be documented in the individual's record. The use of telemedicine should <u>not</u> be driven by the practitioner's/agency's convenience or preference.
Required Components		 Any diagnosis given to an individual must come from persons identified in O.C.G.A Practice Acts as qualified to provide a diagnosis. These practitioners include a licensed clinical social worker, licensed psychologist, licensed marriage and family therapist, licensed professional counselor, a physician or a PA or APRN (NP and CNS-PMH) working in conjunction with a physician with an approved job description or protocol. The behavioral health assessment process must include a face-to-face comprehensive clinical assessment with the youth. Beyond this face-to-face assessment, additional collateral information gathered from the youth, from family members/caregivers, significant others, other involved agencies/treatment providers, and any other relevant individuals may be collected telephonically. An initial Behavioral Health Assessment is required within the first 30 days of service with ongoing assessments completed as demanded by changes with an individual.
Staffing Requirements		 Practitioner scope of practice is often defined in law and/or regulation. As such, while U4 and U5 practitioners are supporting partners in the assessment process, certain aspects of assessment must be completed by practitioners licensed or certified to do so. As indicated, medical, nursing, peer, school, nutritional, etc. staff can provide information from the individual, records, and various multi-disciplinary resources to complete the comprehensive nature of the assessment. Time spent gathering this information may be billed as long as the detailed documentation justifies the time and need for capturing said information. Addictions counselors/SUD-certified practitioners may deliver this service when: a. A presenting individual has a known or suspected substance use disorder (including those with known/suspected co-occurring MH/SUD diagnoses): b. The service is delivered at a location wherein it can be expected that all individuals presenting have a substance use disorder (including those with known/suspected co-occurring MH/SUD diagnoses):
		c. If, during the course of service delivery, there is evidence of either a singular MH condition (i.e. without a co-occurring SUD), or a co-occurring MH condition that rises to a certain level of acuity/complexity (e.g. psychosis, symptoms of major depression, etc.), then additional assessment should be coordinated with a partnering U1-U3 level practitioner who can provide necessary supporting assessment interventions.
Documentation Requirements	7.	In addition to any specific assessment documents resulting from the delivery of this service, there must be a Progress Note in the individual's medical record that supports each claim submitted for this service, in accordance with Part II - Community Service Requirements for BH Providers, Section III - Documentation Requirements, 8. Progress Notes of this manual.
Billing & Reporting Requirements	3 5	A provider may submit an authorization request and subsequent claim for BHA for an individual who may have been erroneously referred for assessment and, and upon the results of that assessment, it is determined that the person does not meet eligibility as defined in this manual. When Telemedicine technology is utilized for the provision of this service in accordance with the allowance in the Service Accessibility section of this definition, the code cited in the Code Detail above with the appropriate GT modifier shall be utilized in documentation and claims submission.

Document 448-73

Filed 11/29/23

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Case 1:16-cv-03088-ELR

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Transaction Code	Transaction Code Detail Coc	e G	Mod N	Mod Mod 2	d Mod	Rate	Code Detail	Code	Mod M	Mod M	Mod Mod 3 4	Rate	
Interprofessional Telephone Consultation	Practitioner Level 1	99446	U1			\$38.81	Practitioner Level 2	99446	U2			\$25.98	
Unit Value	15 minutes						Utilization Criteria	TBD					
	This service includes an inter-professional telephone consultation between physicians (practitione physician/extender with the enrolled DBHDD agency provides or receives specialty expertise opir physician/extender regarding an individual who is enrolled receiving DBHDD services/supports. The Pequest/receive a clinical/medical opinion related to the behavioral health condition; and/or	fessional t led DBHDI ndividual v nedical opi	elephon O agenc vho is er nion rela	e consulta y provides rolled rec	ation betwood or received the serving DE behavior	een physic es special 3HDD serv al health o	This service includes an inter-professional telephone consultation between physicians (practitioner level 1) and/or physician extenders (practitioner level 2) in which the physician/extender with the enrolled DBHDD agency provides or receives specialty expertise opinion and/or treatment advice to/from another treating physician/extender regarding an individual who is enrolled receiving DBHDD services/supports. The physician/extender colleagues collaboratively confer to: Request/receive a clinical/medical opinion related to the behavioral health condition; and/or	ysician ex nt advice t der collea	tenders (pra o/from anot gues collab	actition ther treasonative	er level 2) ating y confer t	in which the	
	Assist the behavioral health/medical provider with diagnosing; and/or Connect/manage the diagnosis and/or management of an individual's	//medical p	rovider	with diagn	osing; an	d/or	tot bood off the distinction with	iviloci odt	ب مرمع و'ادرالا	ţ •	500	4+ C+	
Service	practitioner; and/or	Jois alla/ol	IIIa II a G			שמשומ אושר	טו מוו ווומוזומעמו 5 טופספוונווווט כטוומונוטון אוננוטענ נוופ וופפט וטר נוופ ווומוזומעמו 5 ומכפ-נט-ומכפ כטוונמט		adal y lace-	-10-1aCe	COIIIACI W		
Definition	Consult about alternatives to medication, medical and plan for additional services: and/or	o medicati	on, med	ication co	mbined w	ith psycho	Consult about alternatives to medication, medication combined with psychosocial treatments and potential results of medication usage; and/or	ults of mec	ication usa	ige; and	/or		
	Coordinate or revise a treatment plan; and/or	ment plan;	and/or	_									
	Understand the complexitie	s of co-oc	urring n	nedical co	nditions c	in the indiv	Understand the complexities of co-occurring medical conditions on the individual's behavioral health recovery plan (e.g. kidney failure, diabetes, high blood	olan (e.g. l	idney failur	re, diab	etes, high	poold	
	pressure, etc.); and/or												
	 Reviewing the individual's progress for the purposes of collaborative treatment outcomes. 	rogress fo	r the pui	rposes of	collabora	ive treatm	ent outcomes.						
Admission Criteria	Individual must meet the Adr Individual must be a register Individual must be a register.	mission Cri	teria ele t of DBF	ments as IDD services	defined in	the Psych	Individual must meet the Admission Criteria elements as defined in the Psychiatric Treatment definition herein; and Individual must be a registered recipient of DBHDD services (in the Georgia Collaborative ASO system); and Individual must be a registered recipient of DBHDD services (in the Georgia Collaborative ASO system); and	and the second	\$ C				
		יוסוו טו שומיו	פבו ונמנוטי	i oi syiiipi	COIIIS LIIGI	ובחחוום ווג	individual iliast liave a condition of presentation of symptoms that require the advice, opinion, and/or condition in a supporting private intermental and the educion of the educion of the condition of the educion of	וו אווו מי	d film loddn	Jugalola	וועבעונוומע		
Continuing Stay Criteria	 Individual continues to meet the admission criteria; or Individual exhibits acute disabling conditions of sufficient severity to bring about a significant impairmen Individual continues to present symptoms that are likely to respond to pharmacological interventions; or Individual continues to demonstrate symptoms that are likely to respond or are responding to medical in Individual continues to require management of pharmacological treatment in order to maintain symptom 	the admis abling conc int symptor instrate syr	sion crite litions of ns that a nptoms ment of	eria; or sufficient are likely t that are lil pharmaco	severity or respondely to respondely to respondely to respondely to respondely to respondent to the secondely to the secondely t	to bring abut to pharm spond or all attentions at the spond or all attents in	Individual continues to meet the admission criteria; or Individual continues to meet the admission criteria; or Individual exhibits acute disabling conditions of sufficient severity to bring about a significant impairment in day-to-day functioning; or Individual continues to present symptoms that are likely to respond to pharmacological interventions; or Individual continues to demonstrate symptoms that are likely to respond or are responding to medical interventions; or Individual continues to require management of pharmacological treatment in order to maintain symptom remission.	to-day fun ons; or on.	ctioning; or				
Discharge Criteria	Individual no longer meets criteria defined in the admission criteria above.	a defined ir	the adı ו	nission cr	iteria abo	ve.							
Clinical Exclusions	Individuals are inappropriate for r	nedical co	nsultatio	n when th	e physici	ลท/extende	Individuals are inappropriate for medical consultation when the physician/extender needs more information than can be provided telephonically by the health provider.	be provid	ed telephon	nically b	y the hea	th provider.	
Required Components	A consultation request from a medical condition; and This service may be utilized imited service that stabilizes	a physiciar at various puttle individual	//extendi ooints in ual and	er seeking the indivir moves hir	the specdual's con	ialty opinic rrse of tree	A consultation request from a physician/extender seeking the specialty opinion or guidance of a physician/extender while treating an individual with a co-morbid medical condition; and This service may be utilized at various points in the individual's course of treatment and recovery; however, each intervention is intended to be a discrete timelimited service that stabilizes the individual and moves him/her to the appropriate course of treatment/level of care.	der while t intervent re.	reating an i	individu ded to k	al with a c	o-morbid	
Staffing Requirements	 The practitioner must be employed by a DBHDD enrolled Tier I or Tier II agency. Practitioners able to provide consultation are those who are recognized as levels. The practitioner must devote full attention to the individual served and cannot pre and in the related claim/encounter/submission. 	consultatic full attentinunter/subn	a DBHDI on are th on to the	D enrolled ose who a individua	Tier I or are recogn Il served	Tier II agen nized as le and cannot	The practitioner must be employed by a DBHDD enrolled Tier I or Tier II agency. Practitioners able to provide consultation are those who are recognized as levels 1-2 practitioners in the Service X Practitioner Table A included herein; and The practitioner must devote full attention to the individual served and cannot provide services to other individuals during the time identified in the medical re and in the related claim/encounter/submission.	X Practiti	oner Table , he time ide	A includ	ded hereir the mec	ı; and ical record	
Requirements		full attenti unter/subr	on to the	individue	l served	and canno	t provide services to othe	r individua	r ındividuals during t	r individuals during the time ide	r individuals during the time identified ii	r individuals during the time identified in the med	The practitioner must devote full attention to the individual served and cannot provide services to other individuals during the time identified in the medical record and in the related claim/encounter/submission.

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Behavioral H	Heal	Behavioral Health Clinical Consultation	<u> </u>									
	- 2	When the treating physician or other qualified health p emergency, routine, within 24 hours). When engaging in a consultation, the practitioner shou	other quallours).	fied he	alth pro	viders a	isks for pared t	roviders asks for a consultati uld be prepared to provide:	on, the consultant should establ	When the treating physician or other qualified health providers asks for a consultation, the consultant should establish the urgency of the consultation (e.g., emergency, routine, within 24 hours). When engaging in a consultation, the practitioner should be prepared to provide:	n (e.g.,	
		 a. Individual demographics; b. Date and results of initial or most recent behavioral health evaluation; c. Diagnosis and/or presenting behavioral health condition(s); d. Prescribed medications; and 	s; il or most r iting behav and	ecent b	ehavior salth co	ioral health condition(s)	th evalus);	lation;				Case 1
Clinical Operations	ر ن	000	ders' name al guidanc anding witl	and co	intact ir idvice s eorgia (information. should have a Composite	on. ave the site Meo	following cr dical Board;	edentials and skillset:			:16-cv-C
	4.	 b. Ability to recognize and categorize symptoms; c. Ability to assess medication effects and drug-to-drug interactions; d. Ability to initiate transfers to medical services; and e. Ability to assist with disposition planning. The advice and/or guidance of the consultant should be considered during. 	categorize tition effect is to medic ostition pla	sympt s and d al servi nning. tant sh	oms; rug-to-c ces; an ould be	Irug inte d conside	eraction ered du	ıs; ıring treatme	nt/recovery and discharge planr	o-drug interactions; and oe considered during treatment/recovery and discharge planning, and clearly documented in the individual's	he individual's	3088-ELR
Service Accessibility	2	medical record. Services are available 24-hours/day, 7 days per week, Demographic information collected shall include a prel	s/day, 7 da	ys per	week, a	nd offer inarv de	red by t	and offered by telephone; and minary determination of hearin	nd ring status to determine referral	medical record. Services are available 24-hours/day, 7 days per week, and offered by telephone; and Demographic information collected shall include a preliminary determination of hearing status to determine referral to DBHDD Office of Deaf Services.	S	Doc
	- 2	Requests between the practitioners (or their representative record and noted as an administrative note (i.e. no charge) In addition to all elements defined in this provider manual forms.	ners (or the strative not ed in this plane)	eir repr e (i.e. r provider ician/e	esentat no charç manus tender	ives) mage). Je). Il for the who real	ay be we docun	ritten or verl	ts between the practitioners (or their representatives) may be written or verbal. Either type of request shall be documented in the noted as an administrative note (i.e. no charge). On to all elements defined in this provider manual for the documentation of an encounter, for this service additional elements requests a Consultation from an external provider should clearly document.	Requests between the practitioners (or their representatives) may be written or verbal. Either type of request shall be documented in the individual's medical record and noted as an administrative note (i.e. no charge). In addition to all elements defined in this provider manual for the documentation of an encounter, for this service additional elements required are as follows: a. The DBHDD enrolled agency physician/extender who requests a consultation from an external provider should clearly document:	s medical s follows:	ument 448-
Documentation Requirements		 The External Physician/Extender name and specialty practice area; and A justification of signs, symptoms, or other co-morbid health interactions Advice, guidance, and/or result of the consulting behavioral health proving 	sician/Exte gns, symp and/or res	nder na toms, c ult of th	ime and ir other ie consu	r specie co-mori ulting be	iiry prac bid hea ehavior	otice area; ar Ith interactio al health pro	The External Physician/Extender name and specialty practice area; and A justification of signs, symptoms, or other co-morbid health interactions that reflect why the consultation was requested; and Advice, guidance, and/or result of the consulting behavioral health provider consultation.	on was requested; and		·73 F
		 b. When a practitioner external to the DBHDD enrolled agency requests a consushould clearly document the following: The External Physician/Extender name and specialty practice area; and The requesting reason for the consultation, medical advice and/or guida Any collaborative outcome/plan which will impact the overall IRP 	emal to the t the follow sician/Exte ason for th	ing: nder ne e const	D enrol me and altation,	led age I specia medica	ncy recility practal advice	quests a constice area; are and/or guile	a practitioner external to the DBHDD enrolled agency requests a consultation from the DBHDD enrolled agency phy decument the following: The External Physician/Extender name and specialty practice area; and The requesting reason for the consultation, medical advice and/or guidance provided to the healthcare provider; and Any collaborative outcome/plan which will impact the overall IRP	rolled agency requests a consultation from the DBHDD enrolled agency physician/extender, the practitioner nd specialty practice area; and in, medical advice and/or guidance provided to the healthcare provider; and linears the overall IRP	ne practitioner	Filed 11/29/
Billing & Reporting Requirements	2	The only practitioners who can bill this service are Physic Physician Assessment services through the DBHDD. The DBHDD enrolled provider must consult with an exteninternal consultations are not permitted through this code.	bill this se s through t must consi	rvice al he DBF alt with rough t	e Phys IDD. an exte	icians a	nd Phy ysician	sician Exten	iders who work for a Tier I or Tie .g., emergency department, prin	The only practitioners who can bill this service are Physicians and Physician Extenders who work for a Tier I or Tier II provider who is approved to deliver Physician Assessment services through the DBHDD. The DBHDD enrolled provider must consult with an external Physician/Extender (e.g., emergency department, primary care, etc.). In other words, billing for internal consultations are not permitted through this code.	teliver illing for	23 Pag
Community Support	Sup	pport							:			e 24 of 6
Transaction Code		Code Detail	Code	Mod 1	Mod 2	Mod 3	Mod 4	Rate	Code Detail	Code Mod Mod Mod	Mod Rate	527

Community	noddne													
Transaction	Code Detail	Code	Mod	Mod	Mod	Mod	Rate	Code Detail	Code	Mod	Mod	Mod	Mod	Rate
Code			_	7	က	4				_	7	က	4	

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Community Support	Support											
	Practitioner Level 4, In-Clinic	H2015	U4	U6	\$20.30	Practitioner Level 4, In-Clinic, Collateral Contact	H2015	UK	104	9N	\$20.30	
	Practitioner Level 5, In-Clinic	H2015	n5	90	\$15.13	Practitioner Level 5, In-Clinic, Collateral Contact	H2015	UK	US	90	\$15.13	С
Community Support	Practitioner Level 4, Out-of-Clinic	H2015	U4	U7	\$24.36	Practitioner Level 4, Out-of- Clinic, Collateral Contact	H2015	H.	U4	70	\$24.36	ase 1
	Practitioner Level 5, Out-of-Clinic	H2015	U5	U7	\$18.15	Practitioner Level 5, Out-of- Clinic, Collateral Contact	H2015	¥	U5	10	\$18.15	.:16-c
	Practitioner Level 4, Via interactive audio and video telecommunication systems	H2015	GT	U4	\$20.30	Practitioner Level 5, Via interactive audio and video telecommunication systems	H2015	GT	U5		\$15.13	:v-0308
Unit Value	15 minutes					Utilization Criteria	TBD					88-
	Community Support services consist of rehabilitative, environmental support and resources coordination considered essential to assist a youth/family in gaining access to necessary services and in creating environments that promote resiliency and support the emotional and functional growth and development of the youth. The service	ist of rehab ing environ	llitative, ments th	enviro at pro	nmental support and reso note resiliency and suppo	urces coordination considered es ort the emotional and functional g	ssential to as rowth and d	ssist a evelop	/outh/fa nent of	mily in gainir the youth. Ti	ng access ne service	ELR
	1. Assistance to the youth and family/r	cidue. amily/respo	nsible c	aregive	rs in the facilitation and c	rues of confinantly Support Include. Assistance to the youth and family/responsible caregivers in the facilitation and coordination of the Individual Resiliency Plan (IRP) including providing skills	liency Plan	(IRP) ir	ıcluding	providing sk	slii	D
	support in the youth/family's self-articulation of personal goals and objectives; 2. Planning in a proactive manner to assist the youth/family in managing or preventing crisis situations;	self-articulater to assist	ion of p	ersona :h/famil	goals and objectives; y in managing or prevent	ing crisis situations;)			ocum
	a.	youth, of str	engths	which I	nay aid him/her in achiev	dentification, with the youth, of strengths which may aid him/her in achieving resilience, as well as barriers that impede the development of skills necessary	that impede	the de	velopm	ent of skills r	necessary	ent
		ctioning in	school,	with pe	ers, and with family;			=		11	-	448
	 b. Support to facilitate enhanced natural and age-e to assist them with resiliency-based goal setting 	nanced nat iliency-base	ural and ed goal e	age-a setting	ippropriate supports (incluand attainment);	support to facilitate ennanced natural and age-appropriate supports (including support/assistance with defining what wellness means to the youth in order to assist them with resiliency-based goal setting and attainment);	ınıng wnat w	ellness	means	to tne youtn	In order	8-73
	c. Assistance in the development of interpersonal,	lopment of	interper		community coping and fu	community coping and functional skills (including adaptation to home, school and healthy social	on to home,	school	and hea	althy social		3
Service		opment and	l eventu	al succ	ession of natural support	environments); Encouraging the development and eventual succession of natural supports in living, learning, working, other social environments; Assistance in the continuing of cliffs the vent to soft modular triangle and to soft modular behaviors related to the	er social env	ironme	nts;	, c +	7	Filed
	e. Assistance in the acqui		= 5 8	le your		Assistance in the acquisitor of shirs for the youth to self-recognize emotional triggers and to self-manage behaviors related to the youth's identified emotional disturbance;	טמוומעוטוא ופ	ומופח ונ	o me yo		D.	111
	f. Assistance with persor	nal developr	ment, so	hool p	erformance, work perform	Assistance with personal development, school performance, work performance, and functioning in social and family environment through teaching	nd family en	vironm	ent thro	ugh teaching		/29
	skilis/strategles to ame g. Assistance in enhancir h. Service and resource (ellorate tne e ng social an coordinatior	arrect or d copin i to assi	benav g skills st the y	skills/strategies to ameriorate the effect of behavioral nearth symptoms; Assistance in enhancing social and coping skills that ameliorate life stress Service and resource coordination to assist the youth and family in gainin	skillststrategies to ameriorate the effect of behavioral nearn symptoms; Assistance in enhancing social and coping skills that ameliorate life stresses resulting from the youth's emotional disturbance; Service and resource coordination to assist the youth and family in gaining access to necessary rehabilitative, medical, social and other services and	otional distur ive, medical,	bance	and oth	er services a	pur	/23
	supports; Assistance to vouth an	d other sun	porting	, natural	ni seniices with illiness	supports; Assistance to vouth and other supporting patural resources with illness understanding and self-management [.]	÷					Pag
	j. Any necessary monito	ring and foll	ow-up t	o deter	mine if the services accer	Any necessary monitoring and follow-up to determine if the services accessed have adequately met the youth's needs;	uth's needs;					je 2
	_	youtn/tamil)	, of risk	Indica	ors related to substance	dentification, with the youth/family, of risk indicators related to substance related disorder relapse, and strategies to prevent relapse.	ategies to pr	event r	elapse.			. 5 o
	This service is provided to youth in order to promote stability and build towards age-appropriate functioning in their daily environment. Stability is measured by a decreased number of hospitalizations, by decreased frequency and duration of crisis episodes and by increased and/or stable participation in school and community	n order to prons. by deci	omote s	stability requer	and build towards age-a	ppropriate functioning in their dai episodes and by increased and/o	ly environme r stable part	ent. Sta icipatio	bility is n in sch	measured by ool and com	/ a munity	of 62
	activities. Supports based on the youth's needs are used to promote resiliency while understanding the effects of the emotional disturbance and/or substance use	outh's need	ls are u	sed to	promote resiliency while u	understanding the effects of the e	motional dis	turban	ce and/c	or substance	use	7

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	Community Support	Support	
ng Stay 1. 1. 1. 1. 1. 1. 1. 1. 1. 1. 1. 1. 1.		disorder a will provid	disorder and to promote functioning at an age-appropriate level. The Community Support staff will serve as the primary coordinator of behavioral health services and will provide linkage to community; general entitlements; and psychiatric, substance use disorder, medical services, crisis prevention and intervention services.
ing Stay 1. Je 7. Je 8. Je 9. Je	no		Individual must meet target population criteria as indicated above; and one or more of the following: Individual may need assistance with developing, maintaining, or enhancing social supports or other community coping skills; or ndividual may need assistance with daily living skills including coordination to gain access to necessary rehabilitative and medical services.
ans	ing Stay		Individual continues to meet admission criteria; and Individual demonstrates documented progress or maintenance of community skills relative to goals identified in the Individualized Resiliency Plan.
ans		`	lequate continuing care plan has been established; and one or more of the following:
ans ans define the state of the	ge		s of Individualized Resiliency Plan have been substantially met; or
4 +			dual/family requests discharge and the individual is not imminently in danger of harm to self or others; or
± − − − − − − − − − − − − − − − − − − −			ifer to another service is warranted by change in the individual's condition.
2 6 + 2 + 2 6 6 7		1. Intens	Intensive Family Intervention may be provided concurrently during transition between these services for support and continuity of care for a maximum of four units of CSI has month. If services are provided concurrently. CSI should not be during the provided concurrently.
2. Assist supported by the by		Resili	portionals is services are provided concarrently, constitution be duplicated in 1 services. This service may be adequated Justined in the maintained be encounted.
suppo provid 3. The binary of a and a and a and a and a and a and a agence		-	tance to the youth and family/responsible caregivers in the facilitation and coordination of the Individual Resiliency Plan (IRP) including providing skills
3. The by a. a. b. c. c. d.	Service	ddns	support in the youth/family's self-articulation of personal goals and objectives can be billed as CSI; however, the actual plan development must be billed and
a. b. c. d.			ded in accordance with the service guideline for service Plan Development. Illable activities of Community Support do not include:
b. c. d.			Transportation.
c. d. 1. There 2. Individe 2. Individe 3. Common 3. Conta 4. At least the fall must be agence 5. In the docum 6. Unsure 7. When		ō.	Observation/Monitoring.
d. 1. There 2. Individual 2. Devel 1. Command 2. Command 3. Contain the fair and th		ပ	Tutoring/Homework Completion.
0 + 0 0 N		d.	Diversionary Activities (i.e., activities/time for which a therapeutic intervention tied to a goal on the individual's recovery/resiliency plan (IRP) is not occurring).
i ← 0.6, 4, 10, 10, 10, 10, 10, 10, 10, 10, 10, 10			e is a significant lack of community coping skills such that a more intensive service is needed.
- 51 E E E E E E E E E E E E E E E E E E			duais with the following conditions are excluded from admission unless there is dearly documented evidence of a Iopmental Disability, Autism, Neurocognitive Disorder, Traumatic Brain Injury.
21 kg 4 kg 60 kg			nunity Support services must include a variety of interventions in order to assist the individual in developing:
21 ㎡ 4 ㎡ ⓒ K		æ.	Symptom self-monitoring and self-management of symptoms.
21 Ki 61 Ki 61 Ki		o.	Strategies and supportive interventions for avoiding out-of-home placement for youth and building stronger family support skills and knowledge of the youth
9.6. 4. 10. 10. 10. 10. 10. 10. 10. 10. 10. 10		•	or youth's strengths and limitations.
iw. 4. rv. ro. r			Relapse prevention strategies and plans. minity Support services focus on building and maintaining a theraperitic relationship with the vouth and facilitating treatment and resiliency goals.
4 6 9			Contact must be made with youth receiving Community Support services a minimum of twice each month. At least one of these contacts must be face-to-face and
4 6 9	Required	the se	the second may be either face-to-face or telephone contact (denoted by the UK modifier) depending on the youth's support needs and documented preferences of
			imily.
			At least 50% of CSI service units must be delivered face-to-face with the identified youth receiving the service and at least 60% of all face-to-face service units must be delivered in non-clinic settings over the authorization period (these units are specific to single individual records and are not aggregate across an
			sy/program or multiple payers).
			In the absence of the required monthly face-to-face contact and if at least two unsuccessful attempts to make face-to-face contact have been tried and
			menteo, the provider may bill for a maximum of two telephone contacts in that specified month (denoted by the UN modifier). ccessful attempts to make contact with the individual are not billable.
	, -		When the primary focus of Community Support services for youth is medication maintenance, the following allowances apply:

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Community Support		
Community	These youths are not counted in the offsite servi	
	 b. These youths are not counted in the monthly face-to-face contact requirement; however, face-to-face contact is required every 3 months and monthly calls are an allowed billable service. 	
Staffing Requirements	Community Support practitioners may have the recommended individual-to-staff ratio of 30 individuals per staff member and must maintain a maximum ratio of 50 individuals per staff member. Youth who receive only medication maintenance are not counted in the staff ratio calculation.	Ca
	 Community Support services provided to youth must include coordination with family and significant others and with other systems of care (such as the school system, etc.) juvenile justice system, and child welfare and child protective services when appropriate to treatment and educational needs. This coordination with other child-serving entities is an essential component of Community Support and can be billed for up to 70 percent of the contacts when directly related to the support and enhancement of the youth's resilience. When this type of intervention is delivered, it shall be designated with a UK modifier. The organization must have a Community Support Organizational Plan that addresses the following: Description of the particular rehabilitation, resiliency and natural support development models utilized, types of intervention practiced, and typical daily 	se 1:16-cv-030
Clinical Operations)88-ELR
	 d. Description of how the plan for services is modified or adjusted to meet the needs specified in every Individualized Resiliency Plan. 3. Utilization (frequency and intensity) of CSI should be directly related to the CANS and to the other functional elements of the youth's assessment. 4. When clinical/functional needs are great, there should be complementary therapeutic services by licensed/credential professionals paired with the provision of CSI (individual, group, family, etc.). 	Docume
	 Specific to the "Medication Maintenance Track," individuals who require more than 4 contacts per quarter for two consecutive quarters (as based upon clinical need) are expected to be re-evaluated with the CANS for enhanced access to CSI and/or other services. The designation of the CSI "medication maintenance track" should be lifted and exceptions stated above in A.10. are no longer applied. To promote access, providers may use Telemedicine as a tool to provide direct interventions to individuals for whom English is not their first language. Examples of this include: 	ent 448-73
Service Accessibility	 the use of one-to-one service intervention via Telemedicine, connecting the individual to a practitioner who speaks the individual's language versus use of interpreters; and/or the use of an interpreter via Telemedicine to support the practitioner in delivering the identified service. 	Filed 1
	Telemedicine may only be utilized when delivering this service to an individual for whom English is not their first language. The individual/family must consent to the use of this modality. This consent should be documented in the individual's record. The use of telemedicine should <u>not</u> be driven by the practitioner's/agency's convenience or preference. 1. When a billable collateral contact is provided, the H2015UK reporting mechanism shall be utilized. A collateral contact is classified as any contact that is not face-	L1/29/23
Billing & Reporting Requirements		Page
Community	Community Transition Planning	27 of 62
Transaction	Code Detail Code Mod Mod Mod Rate Code Detail Code Mod Mod Rate Rate Rate Code Detail	27

Community	Transition Planning											
Transaction	Code Detail	Code Mod Mod Mod Mod Rate	Mod	Mod	Mod	Mod	Rate	Code Detail	Code Mod Mod	Mod	Mod	
Code			_	2	က	4				_	2	(.,
FV 23 - 3rd Onar	FV 23 = 3rd Onarter Provider Mannal for Comminity Behavioral Health Providers (January 1 2023)	v Rehavi	oral He	alth Dr	ovide.	re (Jan	lary 1	70231				

Mod 4

Mod 3

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Community 7	Community Transition Planning							
Community	Community Transition Planning (State Hospital)	T2038	ZH	\$20.92	Community Transition Planning (Jail / Youth Detention Center)	T2038	ZJ	\$20.92
Transition Planning	Community Transition Planning (Crisis Stabilization Unit)	T2038	ZC	\$20.92	Community Transition Planning(Other)	T2038	20	\$20.92
	Community Transition Planning (PRTF)	T2038	ZP	\$20.92				
Unit Value	15 minutes				Utilization Criteria	Availabl who me	Available to those currently in qualifying facilities who meet the DBHDD Eligibility Definition	ng facilities ition
	Community Transition Planning (CTP) is a service provided by Tier I, Tier II and IFI providers to address the care, service, and support needs of youth to ensure coordinated plan of transition from a qualifying facility to the community. Each episode of CTP must include contact with the individual prior to release from a facility. Additional Transition Planning activities include educating individual, family, and/or caregiver on service options offered by the chosen primary service agency; participating in facility treatment team meetings to develop a transition plan.	a ser qualifying elephonic n service u	rvice programations	ovided by Tier 1, Tier II and I. to the community. Each epis t with the individual prior to re offered by the chosen primar	vided by Tier 1, Tier II and IFI providers to address the care, service, and support needs of youth to ensure a to the community. Each episode of CTP must include contact with the individual, family, or caregiver with a with the individual prior to release from a facility. Additional Transition Planning activities include educating the offered by the chosen primary service agency; participating in facility treatment team meetings to develop a	ervice, and with the ind ansition Pla ansition Pla acility treat	support needs of youth to e ividual, family, or caregiver oning activities include edument team meetings to dev	nsure a vith a cating the elop a
0	In partnership between other community service providers and the hospital/f facility staff, the community service agency maintains responsibility for carrying out transitional activities either by the individual's chosen primary service coordinator or by the service coordinator's designated Community Transition Liaison. CTP may also be used for Community Support staff, ACT team members and Certified Peer Specialists who work with the individual in the community or will work with the individual.	unity servi dividual's ut staff, AC establish	ice prov chosen T team	iders and the hospital/f facility primary service coordinator or members and Certified Peer t with the individual.	y staff, the community service age or by the service coordinator's desi Specialists who work with the indi	ncy mainta ignated Co vidual in th	ins responsibility for carrying mmunity Transition Liaison. e community or will work wit	out CTP may h the
Definition	은	intions to connection then a reli	ensure n with th lationsh	the youth, family, and/or care ne youth/parent/caregiver thro ip.	consists of the following interventions to ensure the youth, family, and/or caregiver transitions successfully from the facility to their local community: Establishing a connection or reconnection with the youth/parent/caregiver through supportive contacts while in the qualifying facility. By engaging with the youth, this helps to develop and strengthen a relationship.	the facility he qualifyin	to their local community: g facility. By engaging with	he youth,
	 Educating the youth/parent/caregiver about local allows the youth/parent/caregiver to make self-di Participating in qualifying facility team meetings e 	giver abo er to make team me	out local e self-di etings ε	community resources and someted, informed choices on sepecially in person centered	Educating the youth/parent/caregiver about local community resources and service options available to meet their needs upon transition into the community. This allows the youth/parent/caregiver to make self-directed, informed choices on service options to best meet their needs, Participating in qualifying facility team meetings especially in person centered planning for those in an out-of-home treatment facility, to share hospital and	eir needs u needs; ne treatme	oon transition into the comm nt facility, to share hospital a	unity. This and
	community information related to personal strengths, available sug 4. Linking the youth with communit	o estimate pports an ty services	ed lengt id asset is includ	th of stay, present problems r s, medical condition, medical ing visits between the youth a	community information related to estimated length of stay, present problems related to admission, discharge/release criteria, progress toward recovery goals, personal strengths, available supports and assets, medical condition, medication issues, and community-based service needs; Linking the youth with community services including visits between the youth and the Community Support staff, or IFI team members who will be working with the	ease criteri service net or IFI team	 a, progress toward recovery eds; members who will be worki 	goals, ng with the
	youth/parent/caregiver in the cor 5. Conducting any screenings or ne	mmunity t ecessary	to impro assess	we the likelihood of the youth ments to engage the youth a	youth/parent/caregiver in the community to improve the likelihood of the youth accepting services and working toward change. Conducting any screenings or necessary assessments to engage the youth and refer them to appropriate services.	oward chantes.	ge.)
	è	ility while i	in one c	of the following qualifying faci	lities:			
Admission Criteria	 Crisis Stabilization Unit (CSU), Psychiatric Residential Treatment Facility (PRTF) Jail/Youth Development Center (YDC), or 	int Facility (YDC), or	y (PRTF r	'(:				
Continuing Stay Criteria	Same as above.	ric Hospit	(al).					

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munity 1	Community I ransition Planning	
Discharge Criteria	 Individual/family requests discharge; or Individual no longer meets DBHDD Eligibility; or Individual is discharged from a qualifying facility. 	
Clinical Exclusions	Individuals with the following conditions are excluded from admission unless there is clearly documented evidence of a co-occurring Behavioral Health condition: Developmental Disability, Autism, Neurocognitive Disorder, Traumatic Brain Injury.	Cas
Required Components	Prior to Release from a Qualifying Facility. When an individual is admitted to a Qualifying Facility, a community transition plan in partnership with the facility is required. Evidence of planning shall be recorded, and a copy of the Plan shall be included in both the youth's hospital and community record.	e 1:1
	e needs for immediate engagement, yet there is restricted access to the setting, the initial le onset of treatment/support. Youd three (3) months. I after the team becomes engaged with the individual and comes to know the individual. Swards transition into the community (as defined in the CTP guideline) and are expected to or the detail.	6-cv-03088-ELR
Operations	a. Telephone and Face-to-face contacts with youth/family/caregiver; b. Participating in youth's clinical staffing(s) prior to their discharge from the facility; c. Applications for resources and services prior to discharge from the facility, including: i. Healthcare; ii. Entitlements for which they are eligible; iii. Education; iv. Consumer Support Services; v. Applicable waivers, i.e., PRTF, and/or Intellectual and/or Developmental Disabilities (I/DD); and vi. Obtaining legal documentation/identification(s).	Document 448-7
Service Accessibility	ng facility discharges or releases 7 days a week). or via telephone conferencing.	3 F
Billing & Reporting Requirements	g. release from hospital or qualifying facility in order to bill for this service.	iled 11
Documentation Requirements	1. A documented Community Transition Plan for all individuals. 2. Documentation of all face-to-face and telephone contacts and a description of progress with Community Transition Plan implementation and outcomes.	./29/2:

Crisis Intervention	ention													
Transaction	Code Detail	Code Mod	Mod	Mod	Mod Mod Rate	lod		Code Detail	Code Mod Mod Mod Mod	Mod	Mod	Mod	Vod	Rate
Code			_	2	3					_	7	3	_	
	Practitioner Level 1, In-Clinic	H2011 U1	U1	9N			\$58.21	Practitioner Level 1, Out-of-Clinic	H2011 U1	U1	U7			\$74.09
.;	Practitioner Level 2, In-Clinic	H2011 U2	U2	Ole			\$38.97	Practitioner Level 2, Out-of-Clinic H2011 U2	H2011	U2	U2			\$46.76
Crisis	Practitioner Level 3, In-Clinic	H2011 U3	U3	Ol6			\$30.01	Practitioner Level 3, Out-of-Clinic	H2011 U3	U3	U7			\$36.68
וופו אפוווסו	Practitioner Level 4, In-Clinic	H2011 U4	U4	Ol6			\$20.30	Practitioner Level 4, Out-of-Clinic H2011 U4	H2011	U4	U7			\$24.36
	Practitioner Level 5, In-Clinic	H2011 U5	U5	90			\$ 15.13	\$ 15.13 Practitioner Level 5, Out-of-Clinic H2011 U5 L	H2011	U5	10			\$ 18.15

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Crisis Intervention	rention											
	Practitioner Level 1, Via interactive audio and video	H2011	GT	U1	\$58.21	Practitioner Level 4, Via interactive audio and video	H2011	GT	4N		\$20.30	
	telecommunication systems					telecommunication systems						
	Practitioner Level 2, Via interactive audio and video	H2011	GT	60	\$38.97	Practitioner Level 5, Via interactive audio and video	H2011	LD LD	US		\$15.13	Ca
	telecommunication systems					telecommunication systems			}			ase
	Practitioner Level 3, Via											9 1
	interactive audio and video telecommunication systems	H2011	GT	U3	\$30.01							:16-
	Practitioner Level 1, In-Clinic, first 60 minutes (base code)	90839	LO	90	\$232.84	Practitioner Level 1, In-Clinic, add-on each additional 30 mins.	90840	5	90		\$116.42	cv-0
	Practitioner Level 2, In-Clinic, first 60 minutes (base code)	90839	U2	90	\$155.88	Practitioner Level 2, In-Clinic, add-on each additional 30 mins.	90840	n2	90		\$77.94	3088
	Practitioner Level 3, In-Clinic, first 60 minutes (base code)	90839	n3	90	\$120.04	Practitioner Level 3, In-Clinic, add-on each additional 30 mins.	90840	U3	90		\$60.02	-ELF
	Practitioner Level 1, In-Clinic, first 60 minutes (base code)	90839	LO	90	\$296.36	Practitioner Level 1, Out-of-Clinic, add-on each additional 30 mins.	90840	2	10		\$148.18	R [
	Practitioner Level 2, In-Clinic, first 60 minutes (base code)	90839	U2	90	\$187.04	Practitioner Level 2, Out-of-Clinic, add-on each additional 30 mins.	90840	U2	U7		\$93.52	Docu
Psychotherapy	Practitioner Level 3, In-Clinic, first 60 minutes (base code)	90839	U3	90	\$146.72	Practitioner Level 3, Out-of-Clinic, add-on each additional 30 mins.	90840	U3	107		\$73.36	men
for Crisis	Practitioner Level 1, Via interactive audio and video telecomminication systems	90839	GT	11 1	\$232.84	Practitioner Level 1, Via interactive audio and video telecommunication systems, addone and additional 30 mins	90840	GT	L)		\$116.42	t 448-73
	Practitioner Level 2, Via interactive audio and video telecommunication systems	90839	GT	n n n n n n n n n n n n n n n n n n n	\$155.88	Practitioner Level 2, Via interactive audio and video telecommunication systems, addon each additional 30 mins	90840	GT	n5		\$77.94	Filed 1
	Practitioner Level 3, Via interactive audio and video telecommunication systems	90839	GT	U3	\$120.04	Practitioner Level 3, Via interactive audio and video telecommunication systems, addon each additional 30 mins	90840	GT	n3		\$60.02	L1/29/23
	Crisis Intervention		15 minutes	ıtes			Crisis In	Crisis Intervention	_	16 units		
Unit Value	Devotodto otroio		2000	rotor		Maximum Daily Units*	Psychotl Crisis, b	Psychotherapy for Crisis, base code	J.	2 encounters		Page
							Psychotherapy Crisis, add-ons	Psychotherapy for Crisis, add-ons	٥٢	4 encounters		e 30 (
Utilization Criteria	TBD											of 62
												27

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Crisis Intervention	rention	
	Services directed toward the support of a child who is experiencing an abrupt and substantial change in behavior which is usually associated with a precipitating situation and which is in the direction of severe impairment of functioning or a marked increase in personal distress. Crisis Intervention is designed to prevent out of home placement or hospitalization. Often, a crisis exists at such time as a child and/or his or her family/responsible caregiver(s) decide to seek help and/or the individual, family/responsible caregiver(s), or practitioner identifies the situation as a crisis. Crisis services are time-limited and present-focused in order to address the immediate crisis and develop appropriate links to alternate services. Services may involve the youth and his/her family/responsible caregiver(s) and/or significant other, as well as other service providers.	Case
Service Definition	The current family-owned safety plan, if existing, should be utilized to help manage the crisis. Interventions provided should honor and be respectful of the child and family's wishes/choices by following the plan as closely as possible in line with appropriate clinical judgment. Plans/advanced directives developed during the Assessment/IRP process should be reviewed and updated (or developed if the individual is a new individual) as part of this service to help prevent or manage future crisis situations.	1:16-cv-030
	Some examples of interventions that may be used to de-escalate a crisis situation could include: a situational assessment; active listening and empathic responses to help relieve emotional distress; effective verbal and behavioral responses to warning signs of crisis related behavior; assistance to, and involvement/participation of the individual (to the extent he or she is capable) in active problem solving planning and interventions; facilitation of access to a myriad of crisis stabilization and other services deemed necessary to effectively manage the crisis; mobilization of natural support systems; and other crisis interventions as appropriate to the individual and issues to be addressed.	088-ELR [
Admission Criteria	 Treatment at a lower intensity has been attempted or given serious consideration; and #2 and/or #3 are met: Youth has a known or suspected mental health diagnosis or substance related disorder; or Youth is at risk of harm to self, others and/or property. Risk may range from mild to imminent; and one or both of the following: Youth has insufficient or severely limited resources or skills necessary to cope with the immediate crisis; or Youth demonstrates lack of judgment and/or impulse control and/or cognitive/perceptual abilities. 	Document 4
Continuing Stay Criteria	This service may be utilized at various points in the youth's course of treatment and recovery; however, each intervention is intended to be a discrete time-limited service that stabilizes the individual and moves him/her to the appropriate level of care.	48-73
Discharge Criteria	 Youth no longer meets continued stay guidelines; and Crisis situation is resolved, and an adequate continuing care plan has been established. 	3 F
Clinical Exclusions	Severity of clinical issues precludes provision of services at this level of care.	iled :
Clinical Operations	In any review of clinical appropriateness of this service, the mix of services offered to the individual is important. The use of crisis units will be looked at by the Administrative Services Organization in combination with other supporting services. For example, if an individual present in crisis and the crisis is alleviated within an hour but ongoing support continues, it is expected that 4 units of crisis will be billed and then some supporting service such as individual counseling will be utilized to support the individual during that interval of service.	11/29/23
Staffing Requirements	 90839 and 90840 are only utilized when the content of the service delivered is Crisis Psychotherapy. Therefore, the only practitioners who can do this are those who are recognized as practitioners for Individual Counseling in the Service X Practitioner Table A. included herein. The practitioner who will bill 90839 (and 90840 if time is necessary) must devote full attention to the individual served and cannot provide services to other individuals during the time identified in the medical record and in the related claim/encounter/submission. 	Page 3
		1 of 627

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Crisis Intervention	ention
	1. All crisis service response times for this service must be within 2 hours of the individual or other constituent contact to the provider agency. 2. Services are available 24-hours/ day, 7 days per week, and may be offered by telephone and/or face-to-face in most settings (e.g. home, school, community, clinic
	3. Demographic information collected shall include a preliminary determination of hearing status to determine referral to DBHDD Office of Deaf Services. 4. To promote access, providers may use Telemedicine as a tool to provide direct interventions to individuals for whom English is not their first language. Examples of this include:
Accessibility	 the use of one-to-one service intervention via Telemedicine, connecting the individual to a practitioner who speaks the individual's language versus use of interpreters; and/or the use of an interpreter via Telemedicine to support the practitioner in delivering the identified service.
	Telemedicine may only be utilized when delivering this service to an individual for whom English is not their first language. The individual/family must consent to the use of this modality. This consent should be documented in the individual's record. The use of telemedicine should not be driven by the practitioner's/agency's convenience or preference.
Additional Medicaid Requirements	The daily maximum within a CSU for Crisis Intervention is 8 units/day.
	 Any use of a telephonic intervention must be coded/reported with a U6 modifier as the person providing the telephonic intervention is not expending the additional agency resources in order to be in the community where the person is located during the crisis. Any use beyond 16 units will not be denied but will trigger an immediate retrospective review. Psychotherapy for Crisis (90839, 90840) may be billed if the following criteria are met: a. The nature of the crisis intervention is urgent assessment and history of a crisis situation, assessment of mental status, and disposition and is paired with psychotherapy, mobilization of resources to defuse the crisis and restore safety and the provision of psychotherapeutic interventions to minimize trauma; and
	 b. The practitioner meets the definition to provide therapy in the Georgia Practice Acts; and c. The presenting situation is life-threatening and requires immediate attention to an individual who is experiencing high distress. d. Other payers may limit who can provide 90839 and 90840 and therefore a providing agency must adhere to those third-party payers' policies regarding billing practitioners.
Billing & Reporting Requirements	The 90839 code is utilized when the time of service ranges between 45-74 minutes and may only be utilized once in a single day. Anything less than 45 minutes can be provided either through an Individual Counseling code or through the H2011 code above (whichever best reflects the content of the intervention). 6. Add-on Time Specificity: a. If additional time above the base 74 minutes is provided and the additional time spent is greater than 23 minutes, an additional encounter of 90840 may be
	b. If the additional time spent (above base code) is 45 minutes or greater, a second unit of 90840 may be billed. c. If the additional time spent (above base code) is 83 minutes or greater, a third unit of 90840 may be billed. d. If the additional time spent (above base code) is 113 minutes or greater, a fourth unit of 90840 may be billed. 7. 90839 and 90840 cannot be submitted by the same practitioner in the same day as H2011 above. 8. 90839 and 90840 cannot be provided/submitted for billing in the same day as 90791, 90792, 90833, or 90836. 9. Appropriate add-on codes must be submitted on the same claim as the paired base code.
	10. When Telemedicine technology is utilized for the provision of this service in accordance with the allowance in the Service Accessibility section of this definition, the code cited in the Code Detail above with the appropriate GT modifier shall be utilized in documentation and claims submission.

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Diagnostic Assessment	Assessment														
Transaction Code	Code Detail	Code	Mod 1	Mod 2	Mod 1	Mod R	Rate	Code Detail	Code	Mod 1	Mod 2	Mod N	Mod Rate		
0::40:40:	Practitioner Level 2, In-Clinic	90791	U2	9N		\$	\$116.90	Practitioner Level 3, In-Clinic	90791	N3	90		36\$	\$90.03	Ca
Psychiatric Diagnostic	Practitioner Level 2, Out-of-Clinic	90791	U2	U7		\$	\$140.28	Practitioner Level 3, Out-of-Clinic	90791	N3	10		\$11	\$110.04	ιse
Evaluation (no medical service)	Practitioner Level 2, Via interactive audio and video telecommunication systems	90791	GT	U2		↔	\$116.90	Practitioner Level 3, Via interactive audio and video telecommunication systems*	90791	GT	n3		36\$	\$90.03	2 1:16-0
Psychiatric Diagnostic	Practitioner Level 1, In-Clinic	90792	7	90		€\$	\$174.63	Practitioner Level 2, Via interactive audio and video telecommunication systems	90792	GT	NZ		\$11	\$116.90	cv-030
Evaluation with	Practitioner Level 1, Out-of-Clinic	90792	D T	10		\$	\$222.26	Practitioner Level 2, In-Clinic	90792	N2	90		\$11	\$116.90	88
medical services)	Practitioner Level 1, Via interactive audio and video telecommunication systems	90792	GT	7		₩	\$174.63	Practitioner Level 2, Out-of-Clinic	90792	N2	70		\$14	\$140.28	-ELR
Unit Value	1 encounter		•					Maximum Daily Units*	2 unit p	er proce	2 unit per procedure code	qe			
Utilization Criteria	TBD														Docu
	Psychiatric diagnostic interview ex	amination	april Jul	histo	inv. men	tal stati	J. WEXE SI	Psychiatric diagnostic interview examination includes a history: mental status exam: evaluation and assessment of physiological phenomena (including co-morbidity	ological	henom	ini) ena	on pulpul	-morbidit		ım
Service Definition	between behavioral and physical differential diagnosis); screening s initiating or continuing services; ar include communication with family	health care and/or asse the disposer	issues) ssment ition. Th	psychi psychi of any v nese are	iny, men latric dis withdrav comple e orderi	agnostic wal sympeted by be	evaluatio ptoms for face-to-far nedical in	responding to any increment and includes a firstory, mental status example assessment or physiological prenoment (including control and physical health care issues); psychiatric diagnostic evaluation (including assessing for co-occurring disorders and the development of a differential diagnosis); screening and/or assessment of any withdrawal symptoms for youth with substance related diagnoses; assessment of the appropriateness of initiating or continuing services; and a disposition. These are completed by face-to-face evaluation of the youth (which may include the use of telemedicine) and may include the use of telemedicine) and may include the use of telemedicine) and may include communication with family and other sources and the ordering and medical interpretation of laboratory or other medical diagnostic studies.	ing disor ing disor oses; ass ay includ	ders an essmel e the us	d the de the of the of the of the se of tel	avelopmer approprie emedicine s.	ot of a ateness o ateness o and me		nent 448-73
Admission		sted mental	illness	or a suk	stance	-related	disorder &	Youth has a known or suspected mental illness or a substance-related disorder and has recently entered the service system; or	system;	or					3
Criteria	2. Youth is in need of annual assessment and re-authorization of service array; or 3. Youth has need of an assessment due to a change in clinical/functional status.	sessment a ment due to	and re-a	uthoriza Ige in cl	ation of linical/fu	zation of service array; o clinical/functional status.	array; or I status.								File
Continuing Stay Criteria	Youth's situation/functioning has changed in such a way that previous assessments are outdated.	shanged in	such a	vay tha	t previo	us asse	ssments a	are outdated.							ed 11
Discharge Criteria	An adequate continuing care plan has been established; and one or more of the following: Individual has withdrawn or been discharged from service; or Individual no longer demonstrates need for continued diagnostic assessment.	plan has be een dischal rates need	een esta rged fro for cont	ablishec m servi inued di	l; and o ce; or agnosti	c asses	ore of the sment.	e following:						-, - 0, - 0	L/29/23
Required Components	When providing diagnostic services to individuals who consultation with a qualified professional as approved	rvices to in rofessional	dividua as app		are deaf y DBHE	i, deaf-bi)D Deaf	are deaf, deaf-blind, or ha by DBHDD Deaf Services.	are deaf, deaf-blind, or hard of hearing, diagnosticians shall demonstrate training, supervision, and/or by DBHDD Deaf Services.	lemonstra	ate trair	ing, su _l	ervision,	and/or	•	P
Staffing Requirements	The only U3 practitioners who can provide Diagnostic Assessment are an LCSW, LMFT, or LPC	n provide Di	agnosti	c Asses	sment	are an L	CSW, LM	FT, or LPC.						ugo .	age :
Service Accessibility	This service may be provided via telemedicine to any record. The use of telemedicine should not be driven.	l via teleme ne should <u>r</u>	dicine to out to display		dividual	//family \ actitioner	who conse	individual/family who consents to this modality. This consent should be documented in the individual's by the practitioner's/agency's convenience or preference.	ed plnoy	docum	ented ir	the indivi	dual's		33 of
														02.	627

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Diagnostic /	Diagnostic Assessment													
	2. 90791 is used when an initial evaluation is provided by a non-physician.	ial evalua	tion is pr	ovided b	y a non-	ohysicia								
Billing and	3. 90792 is used when an ini	iial evalua	tion is pr	ovided b	y a phys	icián, P⁄	A, or APRI	90792 is used when an initial evaluation is provided by a physician, PA, or APRN. This 90792 intervention content would include all general behavioral health	vould inclu	nde all g	general	behavior	al heal	£
Reporting	assessment as well as Medical assessment/Physical	dical asse	ssment/F	Physical	exam be	yond me	ental statu	exam beyond mental status as appropriate.						
cilialità inchair	4. If a Medicaid claim for this	service de	enies for	a Proce	dure-to-F	rocedur	e edit, a m	If a Medicaid claim for this service denies for a Procedure-to-Procedure edit, a modifier (59) can be added to the claim and resubmitted to the MMIS for payment.	im and res	submitte	ed to th	e MMIS f	or payr	nent.
Additional	The daily maximum for Diagno	stic Asses	sment (F	sychiatr	ic Diagno	ostic Inte	rview) for	The daily maximum for Diagnostic Assessment (Psychiatric Diagnostic Interview) for a youth is 2 units. Two units should be utilized only if it is necessary in a complex	be utilize	d only if	it is ne	cessary i	n a cor	yplex
Medicaid	diagnostic case for the diagnos	tician to c	all in a pl	nysician	for an as	sessme	nt to corro	diagnostic case for the diagnostician to call in a physician for an assessment to corroborate or verify the correct diagnosis.	Š.					
Kedulrements														
	•													
Family Outp	Family Outpatient Services: Family Counseling	Counse	eling											
Transaction Code	Code Detail	Code	Mod 1	Mod 2	Mod 3	Mod 4	Rate	Code Detail	Code	Mod	Mod 2	Mod N	Mod F	Rate
	Practitioner Level 2, In-Clinic	H0004	HS.	_ U2	9N		\$38.97	Practitioner Level 2, Out-of-Clinic	H0004	Y.	n2	10		\$46.76
	Practitioner Level 3, In-Clinic	H0004	HS	U3	90		\$30.01	Practitioner Level 3, Out-of-Clinic	H0004	오	N3	U2	0)	\$36.68
	Practitioner Level 4, In-Clinic	H0004	HS	U4	9N		\$20.30	Practitioner Level 4, Out-of-Clinic	H0004	RS	U4	U2	0)	\$24.36
Family – BH	Practitioner Level 5, In-Clinic	H0004	HS	U5	90		\$15.13	Practitioner Level 5, Out-of-Clinic	H0004	오	C2	U2	0)	\$18.15
counseling/	Practitioner Level 2, Via	HOODA	Ţ	Ų I	5		438 07	Practitioner Level 4, Via	HOODA	Ľ	Ų I	<u> </u>	9	\$20.30
client present)	telecommunication systems	2	5	2	7		2.00	telecommunication systems	-	5	2	5)	000
	Practitioner Level 3, Via							Practitioner Level 5, Via					·	
	interactive audio and video	H0004	GT	S E	U3		\$30.01	interactive audio and video	H0004	GT	오	U5	9)	\$15.13
	telecommunication systems		!				1	telecommunication systems		!		!	•	0
	Practitioner Level 2, In-Clinic	H0004	¥!	U2	90		\$38.97	Practitioner Level 2, Out-of-Clinic	H0004		ZD:	/ <u>1</u>	99 (\$46.76
	Practitioner Level 3, In-Clinic	H0004	H	U3	90		\$30.01	Practitioner Level 3, Out-of-Clinic	H0004	光	O3	10	99	\$36.68
	Practitioner Level 4, In-Clinic	H0004	H	U4	90		\$20.30	Practitioner Level 4, Out-of-Clinic	H0004	뚶	4	U2	0)	\$24.36
Family – BH	Practitioner Level 5, In-Clinic	H0004	H	U5	90		\$15.13	Practitioner Level 5, Out-of-Clinic	H0004	壬	C2	U2	03	\$18.15
counseling/ therapy (with	Practitioner Level 2, Via interactive audio and video	H0004	GT	光	61		\$38.97	Practitioner Level 4, Via interactive audio and video	H0004	GT	£	4()	0.	\$20.30
client present)	telecommunication systems							telecommunication systems					•	
	Practitioner Level 3, Via	HOODY	Ţ	Ξ	~		\$30.01	Practitioner Level 5, Via	HOOOA	Ļ	유	<u> </u>	9	415 13
	telecommunication systems	- - - -	-))			telecommunication systems	- 0 0 0	<u>-</u>	1	8	,) - - -
	Practitioner Level 2, In-Clinic	90846	U2	90			\$38.97	Practitioner Level 2, Out-of-Clinic	90846	U2	U2		0)	\$46.76
	Practitioner Level 3, In-Clinic	90846	U3	90			\$30.01	Practitioner Level 3, Out-of-Clinic	90846	U3	U7		0)	\$36.68
, do,	Practitioner Level 4, In-Clinic	90846	U4	90			\$20.30	Practitioner Level 4, Out-of-Clinic	90846	4	U2		0)	\$24.36
therapy w/o the	Practitioner Level 5, In-Clinic	90846	U5	90			\$15.13	Practitioner Level 5, Out-of-Clinic	90846	U2	U2		03	\$18.15
natient present	Practitioner Level 2, Via	0	ŀ	-			0	Practitioner Level 4, Via	0	ŀ	-			0
(appropriate	interactive audio and video	90846	5	NZ N			\$38.97	interactive audio and video	90846	<u>.</u>	D		33	\$20.30
license required)	telecommunication systems							telecommunication systems						
	Practitioner Level 3, Via	97000	F	2			4000	Practitioner Level 5, Via	37000	F	4			7 7 7 7 7 7 7 7 7 7 7 7 7 7 7 7 7 7 7 7
	Interactive audio and video	90846	פֿ	U3			\$30.01	Interactive audio and video	90846	<u>ت</u>	S		7	\$15.13
	telecommunication systems							telecommunication systems						

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	\$46.76	\$36.68	\$24.36	\$18.15		\$20.30	1:		\$15.13	:V-	03	DE P		nt 448-73	Filed			Pag	e 35 o
	\$4	\$3°	\$2.	\$1.		\$2			\$			ss are directed tow siliency Plan. The f the individual and	e restoration, ctivities to enhanc 'ressed though the		ıal support the farr	or others appropr	with the ability to	opulations and	yet been achieved
!	10	U2	U2	U2		7			C2			Service Ilized Re benefit o	oward the entions/a o be add		and mutc	Therapy	ıterferes	family po	ave not
1	N2	N3	7	U2		GI			GT			needs. Idividua for the	ected to interversues t		action (Family	kedly ir	entified	goals h
	90847	90847	90847	90847		90847			90847		TBD	service in the In rovided	nbers dir c clinical c goals/i		on, inter	ınctional	ing (mar	l with ide	support
	Practitioner Level 2, Out-of-Clinic	Practitioner Level 3, Out-of-Clinic	Practitioner Level 4, Out-of-Clinic	Practitioner Level 5, Out-of-Clinic	Practitioner Level 4, Via	interactive audio and video	telecommunication systems	Practitioner Level 5, Via	interactive audio and video	telecommunication systems	Utilization Criteria	A therapeutic intervention or counseling service shown to be successful with identified family populations, diagnoses and service needs. Services are directed toward achievement of specific goals defined by the individual youth and by the parent(s)/responsible caregiver(s) and specified in the Individualized Resiliency Plan. The focus of family counseling is the family or subsystems within the family, e.g., the parental couple. The service is always provided for the benefit of the individual and may or may not include the individual's participation as indicated by the CPT code.	Family counseling provides systematic interactions between the identified individual, staff and the individual's family members directed toward the restoration, development, enhancement or maintenance of functioning of the identified individual/family unit. This may include specific clinical interventions/activities to enhance family roles; relationships, communication and functioning that promote the resiliency of the individual/family unit. Specific goals/issues to be addressed though these services may include the restoration, development, enhancement or maintenance of:		and substance-related disorders and methods of intervention, interaction and mutual support the family	Best practices such as Multi-Systemic Family Therapy, Multidimensional Family Therapy, Behavioral Family Therapy, Functional Family Therapy or others appropriate for the family and issues to be addressed should be utilized in the provision of this service.	Individual must have an emotional disturbance and/or substance-related disorder diagnosis that is at least destabilizing (markedly interferes with the ability to carry out activities of daily living or places others in danger) or distressing (causes mental anguish or suffering); and	Individual's level of functioning does not preclude the provision of services in an outpatient milleu; and Individual's assessment indicates needs that may be supported by a therapeutic intervention shown to be successful with identified family populations and individual's diagnoses.	Individual continues to meet Admission Criteria as articulated above; and Progress notes document progress relative to goals identified in the Individualized Resiliency Plan, but all treatment/support goals have not yet been achieved.
	\$38.97	\$30.01	\$20.30	\$15.13		\$38.97			\$30.01			be successful with identifice outh and by the parent(s)/re hin the family, e.g., the paredicated by the CPT code.	en the identified individual, g of the identified individual g that promote the resilienc rement or maintenance of		40	ultidimensional Family The ed in the provision of this so	r substance-related disorde) or distressing (causes me	provision or services in an supported by a therapeutic	ticulated above; and dentified in the Individualiz
1	90	90	90	90		N2			N3			hown to idual yc tems wit on as in	ns betwe nctionin nctioning nt, enhar		nental illr eutic go	erapy, M be utiliza	ວe and/o n danger	inde me may be	ria as ar o goals i
giilig	U2	N3	V	O5		GT			GT			ervice s the indiving subsystanticipati	teraction nce of fu and fu elopmer		rson's n r therap	mily The should	sturban others ir	not prec eds that	on Crite elative t
Counse	90847	90847	90847	90847		90847			90847			unseling sefined by family or idual's pa	tematic in naintenar nunicatior ation, dev	.; ≅: .;	ips; and of the pei y membe	stemic Fa ddressed	notional di or places	iing does licates ne	t Admissi rogress r
Family Outpatient Services: Family Counseling	Practitioner Level 2, In-Clinic	Practitioner Level 3, In-Clinic	Practitioner Level 4, In-Clinic	Practitioner Level 5, In-Clinic	Practitioner Level 2, Via	interactive audio and video	telecommunication systems	Practitioner Level 3, Via	interactive audio and video	telecommunication systems	15 minutes	A therapeutic intervention or counseling service shown to be successful with identi achievement of specific goals defined by the individual youth and by the parent(s)/focus of family counseling is the family or subsystems within the family, e.g., the paray or may not include the individual's participation as indicated by the CPT code.	Family counseling provides systematic interactions between the identified individual, development, enhancement or maintenance of functioning of the identified individual family roles; relationships, communication and functioning that promote the resiliency services may include the restoration, development, enhancement or maintenance of		 Family roles and relationships; and The family's understanding of the person's mental illness can use to assist their family member therapeutic goals. 	Best practices such as Multi-Systemic Family Therapy, Multidimensional Family Therapy, I for the family and issues to be addressed should be utilized in the provision of this service.		 Individual s level of functioning does not preclude the provision of services in an outpatient milleu; and Individual's assessment indicates needs that may be supported by a therapeutic intervention shown to individual's diagnoses. 	Individual continues to meet Admission Criteria as articulated above; and Progress notes document progress relative to goals identified in the Indivi
Family Outp		Conjoint	Family Psycho-	therapy w/ the	patient presents	a portion or the	entire session	(appropriate	license required)		Unit Value		000	Definition			Admission	Criteria	Continuing Stay Criteria

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m rd}$ Quarter Provider Manual for Community Behavioral Health Providers (January 1, 2023)

Family Outp	Family Outpatient Services: Family Counseling	
Discharge Criteria	 An adequate continuing care plan has been established; and one or more of the following: Goals of the Individualized Resiliency Plan have been substantially met; or Individual/family requests discharge and individual is not in imminent danger of harm to self or others; or Transfer to another service is warranted by change in individual's condition; or 	С
Service Exclusions		ase 1
Clinical Exclusions	10 —	:16-cv-
Required	use disorder co-occurring with one of the following diagnoses: Intellectual/Developmental Disabilities, Autism, Neurocognitive Disorder, and Traumatic Brain Injury. 1. The treatment/service orientation, modality, and goals must be specified and agreed upon by the youth/family/caregiver.	03088
Clinical	g g	-ELR
Service Accessibility	 Services may not exceed 16 Billable units (combined Family Counseling and Family Therapy) in a single day. If clinical need indicates this level of intensity, other services may need to be considered for authorization. To promote access, providers may use Telemedicine as a tool to provide direct interventions to individuals for whom English is not their first language. Examples of this include: the use of one-to-one service intervention via Telemedicine, connecting the individual to a practitioner who speaks the individual's language versus use of interpreters; and/or the use of an interpreter via Telemedicine to support the practitioner in delivering the identified service. 	Document 448-
	Telemedicine may only be utilized when delivering this service to an individual for whom English is not their first language. The individual/family must consent to the use of this modality. This consent should be documented in the individual's record. The use of telemedicine should <u>not</u> be driven by the practitioner's/agency's convenience or preference.	73 Fil
Documentation Requirements	 If there are multiple family members in the Family Counseling session who are enrolled individuals for whom the focus of treatment is related to goals on their IRP, we recommend the following: a. Document the family session in the charts of each individual for whom the treatment is related to a specific goal on the individual's IRP. b. Charge the Family Counseling session units to <u>one</u> of the served individuals. c. Indicate "NC" (No Charge) on the documentation for the other individual(s) in the family session and have the note reflect that the charges for the session are assigned to another family member in the session. 	ed 11/29/23
Billing & Reporting Requirements	 If a Medicaid claim for this service denies for a Procedure-to-Procedure edit, a modifier (59) can be added to the claim and resubmitted to the MMIS for payment. When Telemedicine technology is utilized for the provision of this service in accordance with the allowance in the Service Accessibility section of this definition, the code cited in the Code Detail above with the appropriate GT modifier shall be utilized in documentation and claims submission. 	Page 3
Family Outp	Family Outpatient Services: Family Training Transaction Code Detail	6 of 627

Family Outp	atient Services: Family Trair	ning												
Transaction	Code Detail	Code	Mod	Mod	Mod	Mod	Rate	Code Detail Coc	Code	Mod	Mod	Mod	Mod	Rate
Code			_	2	က	4				1	(.,	~	4	

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				I	6-cv-030	88-ELR	[Documer	nt 448-73	F	iled	11/	29	/23	3	Pa	age	e 3	7 o	f 6	27
	\$20.30	\$15.13	\$24.36	\$18.15	\$20.30	15.13		ed Plan	pecific	, of	ped);					ıtion,		, to			
								e directe siliency	n, ig and s	owledge	prescri					interver		e ability		ons and	2
	90	90	U2	U2	U4	US		ices are zed Re	storatio s trainin	kills, kno	ation as					nods of		s with th		opulatio	,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,
	40	U5	V4	U5	뚶	뚶		aff. Serv Iividuali	d the re s well a	: ention sl	medica					nd meth		iterferes		family c	7
	坐	뚠	光	뚠	GT	GT		iffied sta the Ind	d towar amily, a unit.	ance of	to take					ency, a	•	kedly ir		entified	3
	H2014	H2014	H2014	H2014	H2014	H2014	TBD	by qua cified ir dividual)	directer of the fa //family	nainten t, relaps	member					ery/resili		ng (mar		with ide	,
	Practitioner Level 4, In-Clinic, w/ client present	Practitioner Level 5, In-Clinic, w/ client present	Practitioner Level 4, Out-of-Clinic, w/ client present	Practitioner Level 5, Out-of-Clinic, w/ client present	Practitioner Level 4, Via interactive audio and video telecommunication systems, w/ client present	Practitioner Level 5, Via interactive audio and video telecommunication systems, w/ client present	Utilization Criteria	tified family populations, diagnoses and service needs, provided by qualified staff. Services are directed thal youth and by the parent(s)/responsible caregiver(s) and specified in the Individualized Resiliency Plcus or primary beneficiary of intervention must always be the individual).	and the individual's family members amily unit. This may include support omote the resiliency of the individual	ific goals/issues to be addressed through these services may include the restoration, development, enhancement or maintenance of: Illness and medication self-management knowledge and skills (e.g., symptom management, behavioral management, relapse prevention skills, knowledge of	medications and side effects, and motivational/skill development in taking medication as prescribed/helping a family member to take medication as prescribed); Problem solving and practicing functional support:					resounce access and management shins, and The family's understanding of mental illness and substance related disorders, the steps necessary to facilitate recovery/resiliency, and methods of intervention,	-	Individual must have an emotional disturbance and/or substance-related disorder diagnosis that is at least destabilizing (markedly interferes with the ability to	carry out activities of daily living or places others in danger) or distressing (causes mental anguish or suffering); and	provision of services in an outpartent nimed, and supported by a therapeutic intervention shown to be successful with identified family populations and	
	\$20.30	\$15.13	\$24.36	\$18.15	20.30	15.13		ations, dia the parent neficiary o	dual, staff ndividual/fi ing that pr	ne restorat mptom m	ing medic					orders, th	member.	ed disorde	ing (cause	ices in an ierapeutic	1:50
	90	90	U7	U7	U4	US		d family populi youth and by or primary be	dentified indivi he identified ii n and function	may include the skills (e.g., sy	lopment in tak					nce related dis	ist their family	ubstance-relate	er) or distress	ovision of servi	· · · · · · · · · · · · · · · · · · ·
	N4	US	N4	US	HS HS	SE SE		dentifie dividual ie focus	en the io ning of t unicatio	ervices dge and	kill deve †:	î				substar	e to ass	nd/or su	in dang	v be sur	
	HS	НS	HS	НS	GT	GT		ul with i by the in amily, th	s betwe functio , comm	these s knowle	tional/sl	<u>-</u>			2	ess and	can ns	oance a	s others	that ma	
ing	H2014	H2014	H2014	H2014	H2014	H2014		success' defined to Ive the f	eraction nance of ionships	through igement	d motiva				ont obillo	ental illo	e family	al distur	or place	s needs)
Family Outpatient Services: Family Training	Practitioner Level 4, In-Clinic, w/o client present	Practitioner Level 5, In-Clinic, w/o client present	Practitioner Level 4, Out-of-Clinic, w/o client present	Practitioner Level 5, Out-of-Clinic, w/o client present	Practitioner Level 4, Via interactive audio and video telecommunication systems, w/o client present	Practitioner Level 5, Via interactive audio and video telecommunication systems, w/o client present	15 minutes	A therapeutic interaction shown to be successful with identified family populations, diagnoses and service needs, provided by qualified staff. Services are directed toward achievement of specific goals defined by the individual youth and by the parent(s)/responsible caregiver(s) and specified in the Individualized Resiliency Plan (note: although interventions may involve the family, the focus or primary beneficiary of intervention must always be the individual).	Family training provides systematic interactions between the identified individual, staff and the individual's family members directed toward the restoration, development, enhancement or maintenance of functioning of the identified individual/family unit. This may include support of the family, as well as training and specific activities to enhance family roles; relationships, communication and functioning that promote the resiliency of the individual/family unit.	Specific goals/issues to be addressed through these services may include the restoration, development, enhancement or maintenance of: 1. Illness and medication self-management, knowledge and skills (e.g., symptom management, behavioral management, relapse preve			-		Decourse access and management chills:	- '	interaction and mutual support the family can use to assist their family member.			. Individual's level of full cubining upes flot predidue the provision of services in an outpanent rimieu, and Individual's assessment indicates needs that may be supported by a therapeutic intervention shown to	
ıtpati	무 의	로 흥	Pr W	P.	Pr au sy:	au sy:	15	A to	de G	્રે જે +	2	က	4. r	ი <u>დ</u>	o r	. ∞		-	C	/i (c)	;
Family Ou	•			Family Skills	Development		Unit Value			Service	Definition								Admission	Criteria	

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		Case 1	:16-cv-	0308	8-ELF	₹	Docu	ument	448-7	73	File	d 11/29	/23	Paç	ge 38	of 627
patien	Stay 1. Individual continues to meet Admission Criteria as articulated above; and 2. Progress notes document progress relative to goals identified in the IRP, but all treatment/support goals have not yet been achieved.	 An adequate continuing care plan has been established; and one or more of the following: Goals of the Individualized Resiliency Plan have been substantially met; or Individual/family requests discharge and individual is not in imminent danger of harm to self or others; or Transfer to another service is warranted by change in individual's condition; or Individual requires more intensive services. 	 Designated Crisis Stabilization Unit services and Intensive Family Intervention. This service is not intended to supplant other services such as Personal and Family Support or any day services where the individual may more appropriately receive these services with staff in various community settings. 	Individuals with the following conditions are excluded from admission unless there is clearly documented evidence of a psychiatric condition/substance use disorder co- occurring with one of the following diagnoses: Intellectual/Developmental Disabilities, Autism, Neurocognitive Disorder, and Traumatic Brain Injury.	1. The treatment orientation, modality and goals must be specified and agreed upon by the youth/family/caregiver. 2. The Individualized Resiliency Plan for the individual includes goals and objectives specific to the youth and family for whom the service is being provided.	+	services may need to be considered for authorization. 2. Family Training may not be provided in an Institution for Mental Diseases (IMD, e.g., state or private psychiatric hospital, psychiatric residential treatment facility or Crisis Stabilization Unit with greater than 16 beds). iail. vouth development center (YDC) or prison system.	3. This service may not be provided and billed for youth who are involuntarily detained in Regional Youth Detention Centers (RYDCs) awaiting criminal proceedings, penal dispositions, or other involuntary detainment proceedings. Any exception to this requires supporting documentation from the DJJ partners. The provider holds the rich for accounting the rich for a continuous transfer and rich for accounting the r	4.		 the use of an interpreter via Telemedicine to support the practitioner in delivering the identified service. 	Telemedicine may only be utilized when delivering this service to an individual for whom English is not their first language. The individual/family must consent to the use of this modality. This consent should be documented in the individual's record. The use of telemedicine should <u>not</u> be driven by the practitioner's/agency's convenience or preference.	1. If there are multiple family members in the Family Training session who are enrolled individuals for whom the focus of treatment in the group is related to goals on their IRP, we recommend the following:	a. Document the family session in the charts of each individual for whom the treatment is related to a specific goal on the individual's IRP. b. Charge the Family Training session units to <u>one</u> of the individuals.	c. Indicate "NC" (No Charge) on the documentation for the other individual(s) in the family session and have the note reflect that the charges for the session.	
amily	Continuing Stay Criteria	Discharge Criteria	Service Exclusions	Clinical Exclusions	Required Components				Service Accessibility					Documentation Requirements		

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		(Case	2:1	6-cv-	0308	38-EI	LR	Do	cument	448-7	3 Fil	ed 11/2	29	/23	3	Page	39 of 627
	Rate	\$10.39	\$8.25	\$5.41	\$4.03	09.8\$	\$6.60	\$4.43	\$3.30	\$10.39	\$8.25	\$5.41	\$4.03	\$10.39	\$8.25	\$5.41	\$4.03	
	Mod 4	U7	U7	U7	U7	90	90	90	90	U7	U7	U7	U7					
	Mod 3	U2	U3	40	US	U2	U3	4O	U5	U2	U3	40	OU5					
	Mod 2	光	光	壬	壬	HS	RS.	모	옷	RS.	HS	HS.	HS.	70	U2	U2	U7	
	Mod 1	욧	Ř	오	오	Я Э	오	욧	9	웃	Я	Ř	Ř	N2	U3	D4	U5	
	Code	H0004	H0004	H0004	H0004	90853	90853	90853	90853									
	Code Detail	Practitioner Level 2, Out-of-Clinic, Multi-family group, with client present	Practitioner Level 3, Out-of-Clinic, Multi-family group, with client present	Practitioner Level 4, Out-of-Clinic, Multi-family group, with client present	Practitioner Level 5, Out-of-Clinic, Multi-family group, with client present	Practitioner Level 2, In-Clinic, Multi- family group, without client present	Practitioner Level 3, In-Clinic, Multi- family group, without client present	Practitioner Level 4, In-Clinic, Multi- family group, without client present	Practitioner Level 5, In-Clinic, Multi- family group, without client present	Practitioner Level 2, Out-of-Clinic, Multi-family group, without client present	Practitioner Level 3, Out-of-Clinic, Multi-family group, without client present	Practitioner Level 4, Out-of-Clinic, Multi-family group, without client present	Practitioner Level 5, Out-of-Clinic, Multi-family group, without client present	Practitioner Level 2, Out-of-Clinic	Practitioner Level 3, Out-of-Clinic	Practitioner Level 4, Out-of-Clinic	Practitioner Level 5, Out-of-Clinic	
	Rate	\$8.50	\$6.60	\$4.43	\$3.30	\$10.39	\$8.25	\$5.41	\$4.03	\$8.50	\$6.60	\$4.43	\$3.30	\$8.50	\$6.60	\$4.43	\$3.30	
	Mod 4									90	90	90	90					
_	Mod 3	90	90	90	90	10	10	10	10	U2	U3	4 7	U5					
	Mod 2	NZ	U3	40	U5	U2	U3	40	U5	光	H	光	光	90	90	90	90	
<u></u>	Mod 1	9	НД	역	9	НQ	옂	9	穿	욧	НД	욧	욧	N2	N3	D4	U5	
unselir	Code	H0004	H0004	H0004	H0004	90853	90853	60853	90853									
Group Outpatient Services: Group Counseling	Code Detail	Practitioner Level 2, In-Clinic	Practitioner Level 3, In-Clinic	Practitioner Level 4, In-Clinic	Practitioner Level 5, In-Clinic	Practitioner Level 2, Out-of-Clinic	Practitioner Level 3, Out-of-Clinic	Practitioner Level 4, Out-of-Clinic	Practitioner Level 5, Out-of-Clinic	Practitioner Level 2, In-Clinic, Multi-family group, w/ client present	Practitioner Level 3, In-Clinic, Multi-family group, w/ client present	Practitioner Level 4, In-Clinic, Multi-family group, w/ client present	Practitioner Level 5, In-Clinic, Multi-family group, w/ client present	Practitioner Level 2, In-Clinic	Practitioner Level 3, In-Clinic	Practitioner Level 4, In-Clinic	Practitioner Level 5, In-Clinic	
Group Outp	Transaction Code						9	Sehavioral	counseling and	وا ما ما				Group Peycho-	therapy other	than of a	multiple family group (appropriate license required)	

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Group Outpa	Group Outpatient Services: Group Counseling	
Unit Value	15 minutes TBD Utilization Criteria	
	A therapeutic intervention or counseling service shown to be successful with identified populations, diagnoses and service needs. Services are directed toward achievement of specific goals defined by the youth and by the parent(s)/responsible caregiver(s) and specified in the Individualized Resiliency Plan. Services may	
Service	address goals/issues such as promoting resiliency, and the restoration, development, enhancement or maintenance of: 1. Cognitive skills;	Ca
Definition	Healthy coping mechanisms;	se
	Adaptive behaviors and skills;	1:
	Interpersonal skills;	16
		-C\
	related disorder diagnosis that is at least destabilizing (markedly interferes with the ability to carry out التعلق التع	v-0
Admission	activities of daily living or places others in danger) or distressing (causes mental anguisn or suffering); and The volith's lovel of functioning does not produide the provision of society in an outbodied; and	30
O E GE	provision of services in an outpatient filling, and second to service must be conductive to response by a group milieu.	88-
Continuing Stay	Youth continues to meet admission criteria; and	ΕL
Criteria	2. Youth demonstrates documented progress relative to goals identified in the Individualized Resiliency Plan, but goals have not yet been achieved.	.R
Discharge	Goals of the Individualized Resiliency Plan have been substantially met; or	D
Criteria		OCI
	Transfer to another service/level of care is warranted by change in youth's condition; or	un
	Youth requires more intensive services.	nei
Service		nt .
Exclusions	The absence of empirical evidence for conversion therapy prohibits the use of this intervention and it is not reimbursed by DBHDD.	44
		8-
Clinical	Severity of cognitive impairment precludes provision of services in this level of care.	73
Exclusions	3. There is a lack of social support systems such that a more intensive level of service is needed.	
	onal and Family Support or any day services where the individual may more	Fi
	appropriately receive these services with staff in various community settings.	ile
	/family/caregiver. If there are disparate goals between the youth	d 1
Required	and family, this is addressed clinically as part of the resiliency-building plans and interventions.	.1/:
Components	2. When billed concurrently with IFI services, this service must be curriculum based and/or targeted to a very specific clinical issue (e.g. incest survivor groups, bemetrator droups, service survivor groups).	29/
Ctaffing		23
Stalling Requirements	Maximum face-to-face ratio cannot be more than 10 individuals to 1 direct service staff based on average group attendance.	3
	sists of multiple family units such as a group of two or more parent(s) from different families either	Pa
Clinical	With (FIX) of without (FIX) participation of their children.	ge
Operations	<u> </u>	40
	participarity for a particular group, working with the group to establish necessary group inorths and group and indiaging group dynamics and processes.	of
Billing &	When using 90853, and the intervention meets the definition of Interactive Complexity, the 90785 code will be submitted with the 90853 base code.	62
Reporting	S for payment.	27
Requirements		

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Transaction	1	Group Outpatient Services: Group Training	DC									
Code	Cod	Code Detail	ge	Mod N	Mod N	Mod N	Mod Rate	Code Detail Code Mod Mod	Mod 3	Mod 4	Rate	
	Prac	Practitioner Level 4, In-Clinic	H2014	٦ P	1 40	90	\$4.43	Practitioner Level 4, Out-of-Clinic, w/ H2014 HQ HR client present	₽	U2	\$5.41	Ca
	Prac	Practitioner Level 5, In-Clinic	H2014	n H	N2 (1	90	\$3.30	O Practitioner Level 5, Out-of-Clinic, w/ H2014 HQ HR client present	US	U2	\$4.03	ise 1
Group Skills	Prac	Practitioner Level 4, Out-of-Clinic	H2014	٦ P	U4	10	\$5.41		⊋	90	\$4.43	:16-0
Development	Prac	Practitioner Level 5, Out-of-Clinic	H2014	л Я	US (U2	\$4.03	Practitioner Level 5, In-Clinic, w/o H2014 HQ HS client present	US	90	\$3.30	cv-03
	Prac clier	Practitioner Level 4, In-Clinic, w/	H2014	유	光	U4	U6 \$4.43		4	U2	\$5.41	3088 ₋
	Prac clier	Practitioner Level 5, In-Clinic, w/	H2014 F	HQ	H (US U	U6 \$3.30	Practitioner Level 5, Out-of-Clinic, w/o H2014 HQ HS client present	U5	U7	\$4.03	-ELR
Unit Value	15 n	15 minutes						Utilization Criteria TBD				2
	A th defii pror	A therapeutic interaction shown to be successful with identified populations, diagnoses ar defined by the youth and by the parent(s)/responsible caregiver(s) and specified in the Incpromoting resiliency, and the restoration, development, enhancement or maintenance of:	uccessful (s)/respon n, develor	with ide sible ca ment, e	entified iregive enhanc	popular r(s) and ement c	ions, diag specified or mainter	A therapeutic interaction shown to be successful with identified populations, diagnoses and service needs. Services are directed toward achievement of specific goals defined by the youth and by the parent(s)/responsible caregiver(s) and specified in the Individualized Resiliency Plan. Services may address goals/issues such as promoting resiliency, and the restoration, development, enhancement or maintenance of:	nent of Is/issue	specific s such	goals	Docun
	-	Illness and medication self-management knowledge and skills (e.g., symptom management, behavio medications and side effects, and motivational/skill development in taking medication as prescribed);	gement kr motivatio	nowledg nal/skill	le and develo	skills (e.	g., sympt in taking ı	Illness and medication self-management knowledge and skills (e.g., symptom management, behavioral management, relapse prevention skills, knowledge of medications and side effects, and motivational/skill development in taking medication as prescribed);	cills, kno	owledge	of	nent -
Service	2.	Problem solving skills;)					448
Definition	დ 4	Healthy coping mechanisms; Adaptive skills:										8-73
	5.	Interpersonal skills;										}
	9.	Daily living skills;										Fi
	۲. ه	Resource management skills;	1	-		7	-			-	-	led
	o .	Niowiedge regarding emotional disturbance, substance related disorders and other released to access and build community resources and natural support systems.	ilsturbanc ild comm	e, suos inity rec	tance i source	erated c s and no	isorders (itural sup	Knowledge regarding emotional disturbance, substance related disorders and other relevant topics that assist in meeting the yourns and lamily sineeds, and skills necessary to access and build community resources and natural support systems.	IIII) SI	eeds, a	2	11
	-	Youth must have an emotional dis	turbance/	substar	ce-rela	ted disc	order diag	Youth must have an emotional disturbance/substance-related disorder diagnosis that is at least destabilizing (markedly interferes with the ability to carry out	oility to	carry ou		/29
Admission	(activities of daily living or places others in danger) or distressing (causes mental anguish or suffering); and	others in c	langer)	or distı	essing	causes n	ental anguish or suffering); and				/23
Criteria	્રં હ	The youth's level of functioning does not preclude the provision of services in an outpatient milieu; and The individual's resiliency goal/s that are to be addressed by this service must be conducive to respons	bes not pre	eclude t be addr	he provessed	vision of bv this (services service m	l he youth's level of tunctioning does not preclude the provision of services in an outpatient milieu; and The individual's resiliency goal/s that are to be addressed by this service must be conducive to response by a group milieu.				3
Continuing Stay	-	Youth continues to meet admission criteria; and	on criteria;	and				- 2				Pa
Criteria	5.	Youth demonstrates documented	progress	relative	to gos	ls ident	ified in the	Youth demonstrates documented progress relative to goals identified in the Individualized Resiliency Plan, but goals have not yet been achieved.	ieved.			ıge
	-	An adequate continuing care plan has been established; and one or more of the following:	n has beer	l establ	shed;	and on	or more	of the following:				4
Discharge	2.	Goals of the Individualized Resiliency Plan have been substantially met; or	ency Plan	have b	en su	bstantia	lly met; o	:				1 0
Criteria	ა. ∠	Youth and family requests discharge and the youth is not in imminent danger of harm to self or others; or	irge and th	ne youth	is not	in immi	nent danç n voutb'o	er of harm to self or others; or مصطلبات عند				of 6
	. r.	Youth requires more intensive services.	rvices.	Wallall	ed by	i aliga	s III youll s	condition, o				27

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Group Outp	Group Outpatient Services: Group Training
Service	When billed concurrently with IFI services, this service must be curriculum based and/or targeted to a very specific clinical issue (e.g. incest survivor groups,
Exclusions	perpetrator groups, sexual abuse survivor groups).
	1. Severity of behavioral health issue precludes provision of services.
	2. Severity of cognitive impairment precludes provision of services in this level of care.
Clinical	3. There is a lack of social support systems such that a more intensive level of service is needed.
Fychisions	4. This service is not intended to supplant other services such as IID/IDD Personal and Family Support or any day services where the individual may more
Lycinsions	appropriately receive these services with staff in various community settings.
	5. Youth with the following conditions are excluded from admission unless there is clearly documented evidence of a psychiatric condition overlaying the behavioral
	health diagnosis: Intellectual/Developmental Disabilities, Autism, Neurocognitive Disorder, and Traumatic Brain Injury.
Required	The functional goals addressed through this service must be specified and agreed upon by the youth/family/caregiver. If there are disparate goals between the youth
Components	and family, this is addressed clinically as part of the resiliency building plans and interventions.
Staffing Requirements	Maximum face-to-face ratio cannot be more than 10 individuals to 1 direct service staff based on average group attendance.
	1. Out-of-clinic group skills training is allowable and clinically valuable for some individuals; therefore, this option should be explored to the benefit of the individual. In this event, staff must be able to assess and address the individual needs and progress of each individual to assess and address unline transportation in the community, and training may be able to assess and individuals to assess and individuals to assess and individual transportation in the community, and training may be able to assess and individual transportation in the community, and training may be able to assess and individuals to assess and individual training in the community.
Clinical	understand the bus schedule in a way that makes sense to them, to address questions/concerns each may have about how to use the bus, perhaps to spend
Opolation 5	time riding the bus with the individuals and assisting each to understand and become comfortable with riding the bus in accordance with individual goals, etc.)
	2. The membership of a multiple family Group Training session (H2014 HQ) consists of multiple family units such as a group of two or more parent(s) from different
	families either with (HR) or without (HS) participation of their child/children.
Billing &	1. Out-of-clinic group skills training is denoted by the U7 modifier.
Reporting Requirements	

Individual Counseling	sunc	eling													
Transaction Code		Code Detail	Code	Mod	Mod	poM poM poM	lod F	Rate	Code Detail	Code	Mod	poM poM poM	Mod		Rate
				_	2	3 4					_	2	3 2		
		Practitioner Level 2, In-Clinic 90832		U2	90		33	\$64.95	Practitioner Level 2, Out-of-Clinic	90832	U2	U2		0,7	\$77.93
		Practitioner Level 3, In-Clinic	90832	U3	90		33	\$50.02	Practitioner Level 3, Out-of-Clinic	90832	U3	U2		0,7	\$61.13
Individual		Practitioner Level 4, In-Clinic	90832	U4	90		33	\$33.83	Practitioner Level 4, Out-of-Clinic	90832	U4	U2		0,7	\$40.59
Psychotherapy,		Practitioner Level 5, In-Clinic	90832	U5	90		33	\$25.21	Practitioner Level 5, Out-of-Clinic	90832	U5	U2		0,7	\$30.25
insight oriented,		Practitioner Level 2, Via							Practitioner Level 4, Via						
behavior-		interactive audio and video	90832	GT	U2		57	\$64.95	interactive audio and video	90832	GT	4			\$33.83
modifying and/or	5	telecommunication systems							telecommunication systems						
supportive face-	nţea	Practitioner Level 3, Via							Practitioner Level 5, Via						
to-face w/	uim	interactive audio and video	90832	GT	U3		57	\$50.02	interactive audio and video	90832	GT	C2			\$25.21
patient and/or	0 E~	telecommunication systems							telecommunication systems						
family member	S	Practitioner Level 2, In-Clinic	90834	U2	90		99	116.90	\$116.90 Practitioner Level 2, Out-of-Clinic	90834	U2	U2		0,	\$140.28
	nnte: 42	Practitioner Level 3, In-Clinic	90834	U3	90		99	\$90.03	Practitioner Level 3, Out-of-Clinic	90834	U3	U2		0,	\$110.04
	- nim	Practitioner Level 4, In-Clinic 90834	90834	U4	90		97	\$60.89	Practitioner Level 4, Out-of-Clinic	90834	U4	U2		0,7	\$73.07

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\$54.46	\$60.89			\$45.38		\$187.04	\$146.71	\$97.42	\$72.61		\$81.18			\$60.51	\$123.48	\$77.93	\$64.95		\$226.26	\$140.28	\$116.90			eq	a, e	yand by	and the		ø.					
																								A therapeutic intervention or counseling service shown to be successful with identified youth populations, diagnoses and service needs, provided by a qualified	clinician. Techniques employed involve the principles, methods and procedures of counseling that assist the youth in identifying and resolving personal, social, social, social, intranersonal concerns. Individual counseling may include face-to-face in or out-of-clinic time with family members as long as the	is on the individual. Services are directed toward achievement of specific goals defined by the vouth and by	the parent(s)/responsible caregiver(s) and specified in the Individualized Resiliency Plan. These services address goals/issues such as promoting resiliency, and the		The illness/emotional disturbance and medication self-management knowledge and skills (e.g., symptom management, behavioral management, relapse					
10		4		<u> </u>	S	10	10	10	10		7			O2	107	20	N2		U2	10	N2			provided	olving per Sembers a	defined b	romoting		nanagem					
U5		GT		Ç	5	n2	n3	4	CS		GT			ET CT	5	n N	GT		U	N2	GT	_		needs,	ind resc	c doals	ich as r	-	ivioral r	cribed);				
90834		90834		70000	90004	90837	90837	90837	90837		90837			90837	90833	90833	90833		90836	90836	90836	TRD	ומח	service I	entifying a	of specific	rissues su		ent, beha	n as pres				
of-Clinic		0 8	IIS	•	2 6	of-Clinic	of-Clinic	of-Clinic	of-Clinic		o.	ns		o: Sin	of-Clinic	of-Clinic			of-Clinic	of-Clinic				ioses and	outh in ide f-clinic fir	evement	ess doals)	nanagem	nedicatio				
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er Leve	er Leve	e audio	nuncatio	er Level	e audio	er Leve	er Leve	er Leve	er Leve	er Leve	e audio	nunicatio	er Level	e audio	erLeve	er Leve	er Leve		er Level	er Leve	er Leve	Critoris		pulation	natassı -face in	ted tow	service		e.g., syr	ment in				
Practitioner Level 5, Out-of-Clinic	Practitioner Level 4, Via	interactive audio and video	telecommunication systems	Practitioner Level 5, Via	Interactive addition and video	Practitioner Level 2. Out-of-Clinic	Practitioner Level 3, Out-of-Clinic	Practitioner Level 4, Out-of-Clinic	Practitioner Level 5, Out-of-Clinic	Practitioner Level 4, Via	interactive audio and video	telecommunication systems	Practitioner Level 5, Via	interactive audio and video	Practitioner Level 1. Out-of-Clinic	Practitioner Level 2, Out-of-Clinic	Practitioner Level 2		Practitioner Level 1, Out-of-Clinic	Practitioner Level 2, Out-of-Clinic	Practitioner Level 2	I Hilization Oritoria	OIIIIZAIIOI	youth po	inseling ti e face-to-	are direct	ลก. These) skills (ı	l develop				
\$45.38	\$116.90			\$90.03		\$155.87	\$120.04	\$81.18	\$60.51		\$155.87			\$120.04	\$97.02	\$64.95	\$97.02		\$174.63	\$116.90	\$174.63	fies		h identified	ures of cou may includ	L Services	siliency Pla		owledge ar	prevention skills, knowledge of medications and side effects, and motivational/skill development in taking medication as prescribed);				
								·														1 encounter (Note: Time-in/Time-out is required in the documentation as it justifies		essful with	id proced	individua	alized Re		ement kn	and motiv				
																						entation		oons ec	hods an	on the	Individu	نت	-manag	effects, a				
90		N2		-	3	90	90	90	90		NZ			N3	90	90	5		Ole	90	2	docum		own to	es, met	focus is	d in the	ance o	ion self	d side (
U5		E GT			5	U2					GI			GI	5	1	GT		1	U2	E GT	ed in the		vice sho	principle	and the	pecified	nainten	nedicat	ions an				
90834		90834		70000	9000	90837	90837	90837	90837		90837			90837	90833	90833	90833		90836	90836	90836	is require		eling ser	olve the	redividual is present for part of the session and the focus	(s) and s	restoration, development, enhancement or maintenance of:	ice and r	medicat	skills;			
Practitioner Level 5, In-Clinic	Via	video	ystems	Via	veterne	In-Clinic	In-Clinic	In-Clinic	In-Clinic	Via	video	ystems	Via	l video vstems	In-Clinic	In-Clinic			Practitioner Level 1, In-Clinic	Practitioner Level 2, In-Clinic		Time-out		or couns	oyed Invi	t of the s	aregiver(nhancer	disturban	ledge of	Problem solving and cognitive skills;	nisms;	d SKIIIS;	ō
evel 5, 1	evel 2,	idio and	cations	evel 3,	Julo alla Pation sy	evel 2.	evel 3.	evel 4,	evel 5,	evel 2,	idio and	cation s	evel 3,	idio and	evel 1.	evel 2.	evel 1		evel 1,	evel 2,	evel 1	ime-in/7	billed)	ention c	ss empli	for par	nsible c	ment, e	otional c	s, know	g and c	mecha	viors an	KIIIS; an
titioner	Practitioner Level 2, Via	interactive audio and video	relecommunication systems	Practitioner Level 3, Via	Interactive audio and video	refeculification systems Practitioner Level 2, In-Clinic	Practitioner Level 3, In-Clinic	Practitioner Level 4, In-Clinic	Practitioner Level 5, In-Clinic	Practitioner Level 2, Via	interactive audio and video	telecommunication systems	Practitioner Level 3, Via	interactive audio and video	Practitioner Level 1. In-Clinic	Practitioner Level 2, In-Clinic	Practitioner Level 1		titioner L	titioner L	Practitioner Level 1	(Note: 7	which code above is billed)	ic interv	schnique intraner	presen)/respoi	develop	ess/em	tion skill	n solvin	Healthy coping mechanisms	Adaptive benaviors and skills;	Interpersonal skills; and
Prac	Prac	inter	TeleC	Prac	teler	Prac	Prac	Prac	Prac	Prac	inter	telec	Prac	inter	Prac	Prac	Prac		Prac	Prac	Prac	counter	sh code	erapeul	ician. It	vidual is	parent(s	oration,	The illn	preven	Proble	Health)	Adaptin	Interpe
									S	ətuni	m 06	<u>)</u> ~				nţes	nim 08	<u>e~</u>	5		uim - <u>24</u> ~	1 er	whit	Αtt	E S	ip ip	the the	rest	<u> </u>	,	2.	က် 🤻	4. r	<u>ဂ</u>
Practi																Psycho-therany	n with	patient and/or	.⊑	conjunction with		alla	מומם					(e					
																Psych	Add-on with	patien	family in	conjur	E&M	onle/\tell) O					0	Definition)				

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7. Bestlevidence-based practice modalities may include (as clinical Behavioral Modification, Behavioral Management, Rational Behapropriate to the individual and clinical issues to be addressed. 1. Youth must have an emotional disturbance/substance-related diactivities of daily living or places others in dangen) or distressing activities of daily living or places others in dangen) or distressing criteria 2. Individual continues to meet admission criteria; and 2. Individual demonstrates documented progress relative to goals in Adequate continuing care plan has been established; and one or Goals of the Individualized Resiliency Plan have been substantis and one or Goals of the Individualized Resiliency Plan have been substantis and individual requires a service approach which supports less or many and a Transfer to another service is warranted by change in individual Exclusions 2. Coals of the Individualized Resiliency Plan have been substantis and individual requires a service approach which supports less or many and a transfer to another service is warranted by change in individual Exclusions 3. The absence of empirical evidence for conversion therapy prohibits and services and intensive Family I Severity of behavioral health disturbance precludes provision of services and Intensive Family I Severity of behavioral health disturbance precludes provision of services and Intensive Intellectual/Developmental Disabilities, Autism, Neurr Required 2. Severity of behavioral health disturbance precludes provision of services and supervisors of those providing this service are based counseling practices. 3. There is no outlook for improvement with this particular service. Individuals with the following conditions are excluded from admit diagnosis: Intellectual/Developmental Disabilities, Autism, Neurr Passad counseling practices. 2. 90833 and 90836 are utilized with EM CPT Codes as an add-on of this include: 3. The use of one-to-one service intervention via Telemedicine as a toolt of the use of an interpreter via	
ng Stay 1. Youth mus activities of 2. The youth 1. Individual 2. Individual 2. Individual 3. Individual 4. Transfer to 5. Individual 5. Individual 6. Severity of 2. Severity of 3. There is not 5. Individual 6. Severity of 3. There is not 5. Individual 6.	Best/evidence-based practice modalities may include (as clinically appropriate): Motivational Interviewing/Enhancement Therapy, Cognitive Behavioral Therapy, Behavioral Modification, Behavioral Management, Rational Behavioral Therapy, Dialectical Behavioral Therapy, Interactive Play Therapy, and others as appropriate to the individual and clinical issues to be addressed.
ng Stay 1. Individual 2. Individual 3. Individual/ 4. Transfer tt 5. Individual/ 6. Individual Designated C The absence 1. Severity o 2. Severity o 3. There is a 4. There is a 4. There is n 5. Individuals diagnosis: d The treatment lents 1. Practitione based count 1. Practitione based count 1. To promote of this incl	Youth must have an emotional disturbance/substance-related disorder diagnosis that is at least destabilizing (markedly interferes with the ability to carry out activities of daily living or places others in danger) or distressing (causes mental anguish or suffering); and The youth's level of functioning does not preclude the provision of services in an outpatient milieu.
1. Adequate 2. Goals of tt 3. Individual 4. Transfer tt 5. Individual Designated C The absence 1. Severity or 2. Severity or 3. There is a 4. There is n 5. Individuals diagnosis: d The treatment 1. Practitione based counts 2. 90833 and 1. To promote of this incl	Individual continues to meet admission criteria; and Individualized Resiliency Plan, but goals have not yet been achieved.
Designated C The absence 1. Severity or 2. Severity or 3. There is a 4. There is not be diagnosis: The treatment The treatment 1. Practitione based council based council based council based council of this incless.	Adequate continuing care plan has been established; and one or more of the following: Goals of the Individualized Resiliency Plan have been substantially met; or Individual/family requests discharge and individual is not in imminent danger of harm to self or others; or Transfer to another service is warranted by change in individual's condition; or Individual requires a service approach which supports less or more intensive need.
1. Severity or 2. Severity or 3. There is a 4. There is n 4. There is n 5. Individuals diagnosis: The treatment 1. Practitione based cou 2. 90833 and 1. To promot of this incl	Designated Crisis Stabilization Unit services and Intensive Family Intervention. The absence of empirical evidence for conversion therapy prohibits the use of this intervention and it is not reimbursed by DBHDD.
The treatment 1. Practitione based cou 2. 90833 and 1. To promot of this incl	Severity of behavioral health disturbance precludes provision of services. Severity of cognitive impairment precludes provision of services in this level of care. There is a lack of social support systems such that a more intensive level of service is needed. There is no outlook for improvement with this particular service. Individuals with the following conditions are excluded from admission unless there is clearly documented evidence of a behavioral health condition overlaying the diagnosis: Intellectual/Developmental Disabilities, Autism, Neurocognitive Disorder and Traumatic Brain Injury.
1. To promot of this incl	The treatment orientation, modality and goals must be specified and agreed upon by the youth/family/caregiver. 1. Practitioners and supervisors of those providing this service are expected to maintain knowledge and skills regarding current research trends in best/evidence-based counseling practices. 2. 90833 and 90836 are utilized with E/M CPT Codes as an add-on for psychotherapy and may not be billed individually.
	To promote access, providers may use Telemedicine as a tool to provide direct interventions to individuals for whom English is not their first language. Examples of this include: • the use of one-to-one service intervention via Telemedicine, connecting the individual to a practitioner who speaks the individual's language versus use of interpreters; and/or • the use of an interpreter via Telemedicine to support the practitioner in delivering the identified service.
Accessibility Telemedicine may only be utilized when delive the use of this modality. This consent should to convenience or preference. 2. Additionally, telemedicine may be utilized for 9. U1 and U2).	Telemedicine may only be utilized when delivering this service to an individual for whom English is not their first language. The individual/family must consent to the use of this modality. This consent should be documented in the individual's record. The use of telemedicine should not be driven by the practitioner's/agency's convenience or preference. Additionally, telemedicine may be utilized for 90833 and 90836 when the service is combined with CPT E&M codes and delivered by a medical practitioner (Level U1 and U2).

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Individual Counseling	unseling
	1. When 90833 or 90836 are provided with an E/M code, these are submitted together to encounter/claims system.
	2. 90833 is used for any intervention which is 16-37 minutes in length.
	3. 90836 is used for any intervention which is 38-52 minutes in length.
0 = 0:11:0	4. 90837 is used for any intervention which is greater than 53 minutes.
Donorting	5. If a Medicaid claim for this service denies for a Procedure-to-Procedure edit, a modifier (59) can be added to the claim and resubmitted to the MMIS for payment
Poduiroments	with two exceptions: If the billable base code is either 90833 or 90836 and is denied for Procedure-to-Procedure edit, then a (25) modifier should be added to the
ויפלמוו פווופוווים	claim resubmission.
	6. Appropriate add-on codes must be submitted on the same claim as the paired base code.
	When Telemedicine technology is utilized for the provision of this service in accordance with the allowance in the Service Accessibility section of this definition, the
	code cited in the Code Detail above with the appropriate GT modifier shall be utilized in documentation and claims submission.
	1. When 90833 or 90836 are provided with an E/M code, they are recorded on the same intervention note but the distinct services must be separately identifiable.
Documentation	2. When 90833 or 90836 are provided with an E/M code, the psychotherapy intervention must include time in/time out in order to justify which code is being utilized
Requirements	(each code shall have time recorded for the two increments of service as if they were distinct and separate services). Time associated with activities used to meet
	criteria for the E/M service is not included in the time used for reporting the psychotherapy service.

Interactive Complexity	Complexity												
Transaction Code	Code Detail	Code	Mod 1	Mod 2	Mod 3	Mod 4	Rate	Code Detail	Code	Mod 1	Mod 2	Mod N	Mod Rate 4
Interactive Complexity	Interactive complexity (List separately in addition to the code for primary procedure)	90785					\$0.00	Interactive complexity (List separately in addition to the code for primary procedure)	90785	TG			\$0.00
Unit Value	1 Encounter							Utilization Criteria	4 units				
	Interactive Complexity is not a direc This modifier is used when:	t service bu	ut functic	ons as a	modifie	to Psy.	chiatric T	Interactive Complexity is not a direct service but functions as a modifier to Psychiatric Treatment, Diagnostic Assessment, Individual Therapy, and Group Counseling. This modifier is used when:	ndividual	Therap	y, and (Group Co	unseling.
	 Communication with the individual/participant is therefore delivery of care is challenging). 	dual/partici		omplica	ted perh	aps rel	ated to (e	complicated perhaps related to (e.g., high anxiety, high reactivity, repeated questions, or disagreement and	eated que	estions,	or disa	greement	and
Service Definition	2. Caregiver emotions/behaviors complicate the implementation of the IRP. 3. Evidence/disclosure of a sentinel event and mandated report to a third pa	complicate	the impured many	olements dated reg	ution of t	he IRP. third pa	artv (e.g	Caregiver emotions/behaviors complicate the implementation of the IRP. Evidence/disclosure of a sentinel event and mandated report to a third party (e.g abuse or neglect with report to state agency) with initiation of discussion of the	e agency)	with in	itiation	of discus:	sion of the
	sentinel event and/or report with the individual and supporters. 4. Use of play equipment, physical devices, interpreter or translat as practitioner, or when the individual has not developed or ha intervention).	ith the indival devices,	ridual an interpre s not dev	id supporter or tra	rters. inslator or has lo	to overc	some sign essive/re	sentinel event and/or report with the individual and supporters. Use of play equipment, physical devices, interpreter or translator to overcome significant language barriers (when individual served is not fluent in same language as practitioner, or when the individual has not developed or has lost expressive/receptive communication skills necessary for interactive participation in the intervention).	vidual se sary for in	rved is r iteractiv	not flue e partic	nt in sam ipation in	e language the
Admission Criteria Continuing Stay Criteria Discharge Criteria	These elements are defined in the s	pecific corr	panion	service 1	o which	this mc	odifier is e	These elements are defined in the specific companion service to which this modifier is anchored to in reporting/claims submission.	nission.				

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Interactive Complexity	omplexity	
Clinical		
Exclusions		
	1. When this code is submitted, there must be:	
	a. Record of base service delivery code/s AND the Interactive Complexity code on the single note; and	(
Documentation	b. Evidence within the multi-code service note which indicates the specific category of complexity (from the list of items 1-4 in the definition above) utilized	Ca
Requirements	during the intervention.	se
	2. The interactive complexity component relates only to the increased work intensity of the psychotherapy service but does not change the time for the	1
	psychotherapy service.	:16
	1. This service may only be reported/billed in conjunction with one of the following codes: 90791, 90792, 90832, 90834, 90837, 90853, and with the following codes	6- 0
Billing &	only when paired with 90833 or 90836: 99201, 99211, 99202, 99212, 99203, 99213, 99204, 99214, 99205, 99215.	:V-
Reporting	2. This Service Code paired with the TG modifier is only used when the complexity type from the Service Definition above is categorized under Item 4 AND an	03
Requirements	interpreter or translator is used during the intervention. So, if play equipment is the only complex intervention utilized, then TG is not utilized.	30
	3. Interactive Complexity is utilized as a modifier and therefore is not required in an order or in an Individualized Recovery/Resiliency Plan.	38-
		ELR
		?

Medication A	Medication Administration													
Transaction	Code Detail	Code	Mod 1	Mod 2	Mod 3	Mod 4	Rate	Code Detail	Code	Mod 1	Mod 2	Mod 3	Mod F	Rate
	Practitioner Level 2, In-Clinic	H2010	N2	9N)		\$33.40	Practitioner Level 2, Out-of-Clinic	H2010	U2	<u>2</u> 0	,		\$42.51
Comprehensive	Practitioner Level 3, In-Clinic	H2010	N3	90			\$25.39	Practitioner Level 3, Out-of-Clinic	H2010	U3	U2		0,5	\$33.01
Medication	Practitioner Level 4, In-Clinic	H2010	D4	9N			\$17.40	Practitioner Level 4, Out-of-Clinic	H2010	U4	U7		0,7	\$22.14
Services	Practitioner Level 5, In-Clinic	H2010	U5	90			\$12.97							
Therapeutic,	Practitioner Level 2, In-Clinic	96372	U2	90			\$33.40	Practitioner Level 2, Out-of-Clinic	96372	N2	<i>1</i> 0		93	\$42.51
prophylactic or	Practitioner Level 3, In-Clinic	96372	N3	90			\$25.39	Practitioner Level 3, Out-of-Clinic	96372	U3	U2		0,7	\$33.01
injection	Practitioner Level 4, In-Clinic	96372	U4	90			\$17.40	Practitioner Level 4, Out-of-Clinic	96372	U4	U7		0,7	\$22.14
Alcohol, and/or	Practitioner Level 2, In-Clinic	H0020	U2	90			\$33.40	Practitioner Level 4, In-Clinic	H0020	U4	90		07	\$17.40
drug services,														
metnadone administration	Practitioner Level 3, In-Clinic	H0020	N3	90			\$25.39							
and/or service														
Unit Value	1 Encounter							Utilization Criteria	TBD					
	As reimbursed through this service, medication ad living organism, alters normal bodily function) into	se, medica Jily functic	ıtion ad ın) into	ministrat the body	ion includ of anothe	les the er perso	act of intr on by any	As reimbursed through this service, medication administration includes the act of introducing a drug (any chemical substance that, when absorbed into the body of a living organism, alters normal bodily function) into the body of another person by any number of routes including, but not limited to the following: oral, nasal, inhalant,	tance that, t limited to	when a	absorbed owing: oı	l into the ral, nasa	body o I, inhala	fa int,
Service	intramuscular injection, intravenor	us, topical	, suppo	sitory or	intraocul	ar. Mec	lication a	intramuscular injection, intravenous, topical, suppository or intraocular. Medication administration requires a written service order for Medication Administration and a	ice order fo	or Med	ication A	dministra	ition an	a q
Definition	written order for the medication and the administra	nd the adı	ministra	ition of th	ne medica	ition tha	at complie	ation of the medication that complies with guidelines in Part II, Section 1, Subsection 6 - Medication of the Provider	1, Subsect	tion 6 -	Medicati	on of the	Provid	er
	Manual. The order for and admini	istration o	f medic	ation mu	st be corr	npleted	by memb	Manual. The order for and administration of medication must be completed by members of the medical staff pursuant to the Medical Practice Act of 2009, Subsection	the Medica	al Prac	tice Act c	of 2009, 3	Subsect	ion
	43-34-23 Delegation of Authority	to Nurse	and Phy	sician A	ssistant a	nd mus	st be adm	43-34-23 Delegation of Authority to Nurse and Physician Assistant and must be administered by licensed or credentialed* medical personnel under the supervision of a	d* medical	person	inel unde	r the sup	ervision	n of a

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Medication /	Medication Administration
	physician or registered nurse in accordance with O.C.G.A. This service does <u>not</u> cover the supervision of self-administration of medications (See Clinical Exclusions below).
	The service must include: 1. An assessment, by the licensed or credentialed medical personnel administering the medication, of the youth's physical, psychological and behavioral status in order to make a recommendation regarding whether to continue the medication and/or its means of administration, and whether to refer the youth to the physician for a medication review. 2. Education to the youth and/or family/responsible caregiver(s), by appropriate licensed medical personnel, on the proper administration and monitoring of prescribed medication in accordance with the youth's resiliency plan.
	For individuals who need opioid maintenance, the Opioid Maintenance Type of Care should be requested.
Admission	 Youth presents symptoms that are likely to respond to pharmacological interventions; and Youth has been prescribed medications as a part of the treatment/service array; and Youth/family/responsible caregiver is unable to self-administer/administer prescribed medication because: Although the youth is willing to take the prescribed medication, it is a Class A controlled substance which must be stored and dispensed by medical personnel Although youth is willing to take the prescribed medication, it is a Class A controlled substance which must be stored and dispensed by medical personnel
Criteria	In accordance with state law, or c. Administration by licensed/credentialed medical personnel is necessary because an assessment of the youth's physical, psychological and behavioral status is required in order to make a determination regarding whether to continue the medication and/or its means of administration and/or whether to refer the youth to the physician for a medication review.
	d. Due to the family/caregiver's lack of capacity there is no responsible party to manage/supervise self-administration of medication (refer youth/family for CSI and/or Family or Group Training in order to teach these skills).
Continuing Stay Criteria	Youth continues to meet admission criteria.
Discharge Criteria	 Youth no longer needs medication; or Youth/Family/Caregiver is able to self-administer, administer, or supervise self-administration medication; and Adequate continuing care plan has been established.
Service Exclusions	 Medication administered as part of Ambulatory Detoxification is billed as "Ambulatory Detoxification" and is not billed via this set of codes. Must not be billed in the same day as Nursing Assessment. For individuals who need opioid maintenance, the Opioid Maintenance service should be requested.
Clinical Exclusions	This service does <u>not</u> cover the supervision of self-administration of medications. Self-administration of medications can be done by anyone physically and mentally capable of taking or administering medications to himself/herself. Youth with mental health issues, or developmental disabilities are very often capable of self-administration of medications even if supervision by others is needed in order to adequately or safely manage self-administration of medication and other activities of daily living.
Required	1. There must be a written service order for Medication Administration and a written order for the medication and the administration of the medication that complies with guidelines in Part II, Section 1, Subsection 6 - Medication of the Provider Manual. The order for and administration of medication must be completed by members of the medical staff pursuant to the Medical Practice Act of 2009, Subsection 43-34-23 Delegation of Authority to Nurse and Physician Assistant. The order must be in the youth's chart. Telephone orders are acceptable provided they are co-signed by the appropriate members of the medical staff in accordance with DBHDD
Components	requirements. 2. Documentation must support that the individual is being trained in the risks and benefits of the medications being administered and that symptoms are being monitored by the staff member administering the medication. 3. Documentation must support the medical necessity of administration by licensed/credentialed medical personnel rather than by the youth, family or caregiver.

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Case 1:16-cv-03088-ELR

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Medication Administration	Adr	ninistration
	4.	4. Documentation must support that the youth AND family/caregiver is being trained in the principles of self-administration of medication and supervision of self-
		administration or that the youth/family/caregiver is physically or mentally unable to self-administer/administer. This documentation will be subject to scrutiny by the
		Administrative Services Organization in reauthorizing services in this category.
	5.	This service does not include the supervision of self-administration of medication.
Staffing Requirements	<u>ಹ</u>	Qualified Medication Aides working in a Community Living Arrangement (CLA) may administer medication only in a CLA.
	1.	Medication administration may not be billed for the provision of single or multiple doses of medication that an individual has the ability to self-administer, either
		independently or with supervision by a caregiver, either in a clinic or a community setting. In a group home setting, for example, medications may be managed by
		the house parents or residential care staff and kept locked up for safety reasons. Staff may hand out medication to the residents, but this does not constitute
logicil		administration of medication for the purposes of this definition and, like other watchful oversight and monitoring functions, are not reimbursable treatment services.
Operations	2	If individual/family requires training in skills needed in order to learn to manage his/her own medications and their safe self-administration and/or supervision of
Operations		self-administration, this skills training service can be provided via the Community Support or Family/Group Training services in accordance with the person's
		individualized recovery/resiliency plan.
	က	Agency employees working in residential settings such as group homes, are not eligible for CSI or Family/Group Training in the supervision of medication self-
		administration by youth in their care.
	1.	Medication Administration may not be provided in an Institution for Mental Diseases (IMD, e.g., state or private psychiatric hospital, psychiatric residential treatment
		facility or Crisis Stabilization Unit with greater than 16 beds), jail, youth development center (YDC) or prison system.
Accesibility	2	This service may not be provided and billed for youth who are involuntarily detained in Regional Youth Detention Centers (RYDCs) awaiting criminal proceedings,
Accessionity		penal dispositions, or other involuntary detainment proceedings. Any exception to this requires supporting documentation from the DJJ partners. The provider
		holds the risk for assuring the youth's eligibility.
Billing &	1.	If a Medicaid claim for this service denies for a Procedure-to-Procedure edit, a modifier (59) can be added to the claim and resubmitted to the MMIS for payment.
Reporting	2	When Opioid Maintenance type of care is required for an individual, then the authorization and billing parameters set forth in Part I, Section II govern units and
Requirements		initial/concurrent authorization.

Nursing Ass	Nursing Assessment and Health Services	vices												
Transaction	Code Detail	Code	Mod	Mod	Mod	Mod	Rate	Code Detail	Code	Mod	Mod Mod Mod Mod	Mod		Rate
Code			1	2	3	4				1	2	3	4	
	Practitioner Level 2, In-Clinic	T1001	U2	Ol6			\$38.97	Practitioner Level 2, Out-of-Clinic	T1001	U2	U7			\$46.76
	Practitioner Level 3, In-Clinic	T1001	U3	N6			\$30.01	Practitioner Level 3, Out-of-Clinic	T1001	U3	U2			\$36.68
	Practitioner Level 4, In-Clinic	T1001	U4	O6			\$20.30	Practitioner Level 4, Out-of-Clinic	T1001	U4	U7			\$24.36
Nursing	Practitioner Level 2, Via							Practitioner Level 4, Via						
Assessment/	interactive audio and video	T1001	GT	U2			\$38.97	interactive audio and video	T1001 GT U4	GT	4			\$20.30
Evaluation	telecommunication systems							telecommunication systems						
	Practitioner Level 3, Via													
	interactive audio and video	T1001	GT	N3			\$30.01							
	telecommunication systems													
RN Services, up	Practitioner Level 2, In-Clinic	T1002	U2	O6			\$38.97	Practitioner Level 2, Out-of-Clinic	T1002	U2	U2			\$46.76
to 15 minutes	Practitioner Level 3, In-Clinic	T1002	U3	90			\$30.01	Practitioner Level 3, Out-of-Clinic T1002 U3	T1002	N3	U2			\$36.68

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		\$30.01	\$24.36			\$62.35	\$48.91	\$32.48		\$20.30					lical staff	ological and/or	vchosocial	,	d to refer the		d disorder, or to retention,		bstance related	adversely affect			of psychotropic				
		en	107			10	10	U2	:	4					ropriate mec	ig the psycho	nd related ps	-	nine the nee		stance related ain and fluid	3	health or su	which may	[N]	,,	side effects o				
	!	ET C	4			N2	n3	₽	ļ	E1					of app	egardir	ealth a		deterr		or subs eight g		mental	y those	s, etc.);	LV/sin	onitor				; or
		T1002	T1003			96156	96156	96156		96156				TBD	out orders	ssistant r	navioral h		and/or to		al health iptoms, w	: :	dividual's	(especiall	r seizures	റാറ പ്രവ	, and to m			fion.	ir ınctioning
	Practitioner Level 3, Via	interactive audio and video telecommunication systems	Practitioner Level 4, Out-of-Clinic			Practitioner Level 2, Out-of-Clinic	Practitioner Level 3, Out-of-Clinic	Practitioner Level 4, Out-of-Clinic	Practitioner Level 4, Via	interactive audio and video				Utilization Criteria	This service requires face-to-face contact with the vouth/familV/caregiver to monitor, evaluate, assess, and/or carry out orders of appropriate medical staff	pursuant to the Medical Practice Act of 2009, Subsection 43-34-23 Delegation of Authority to Nurse and Physician Assistant regarding the psychological and/or physical problems and general wellness of the voluth. It includes:	Providing nursing assessments and interventions to observe, monitor and care for the physical, nutritional, behavioral health and related psychosocial	rt;	Assessing and monitoring the youth's response to medication(s) to determine the need to continue medication and/or to determine the need to refer the		and other health issues that are either directly related to the mental health or substance related disorder, or to , cardiac and/or blood pressure issues, substance withdrawal symptoms, weight gain and fluid retention,		Consulting with the youth's family/caregiver about medical, nutritional and other health issues related to the individual's mental health or substance related issues:	Educating the youth and family/responsible caregiver(s) on medications and potential medication side effects (especially those which may adversely affect	health such as weight gain or loss, blood pressure changes, cardiac abnormalities, development of diabetes or seizures, etc.);	Consuming with the yournain rainify caregiver (s) about the various aspects of minormed consent (when prescribing occurs/AF NA), Training for self-administration of medication:	mental health, substance disorders or directly related conditions, and to monitor side effects of psychotropic			Youth presents with symptoms that are likely to respond to medical/nursing interventions; or Youth has been prescribed medications as a part of the treatment/service array or has a confounding medical condition.	Youth continues to demonstrate symptoms that are likely to respond to or are responding to medical interventions; or Youth exhibits acute disabling conditions of sufficient severity to bring about a significant impairment in day-to-day functioning; or
		\$38.97	\$20.30		\$20.30	\$38.97	\$30.01	\$20.30	1	\$38.97		\$30.01			ver to moni	elegation of	onitor and o	i's treatmer) to determi		sues that ar od pressure		itional and o	dications an	rdiac abnori	ious aspaci	ostance disc	I staff; and	es.	ursing intervice array o	o or are res about a siç
															uth/familv/cared	tion 43-34-23 D	is to observe, m	urse of the yout	to medication(s		d other health is irdiac and/or blo	-	out medical, nutr	egiver(s) on med	re changes, ca ما والمارة	ə) about iile vai	ental health, su	rs of the medica	nfectious diseas	nd to medical/n ne treatment/se	cely to respond severity to bring
	:	N2	9N		V	90	90	90		NZ		N3		156	the voi	Subsec	rvention	the co	sbonse		lical an etes, ca		iver abo	ble care	d pressi	ation:	sess m	membe	ral for i	o responant	at are lil ifficient
	ļ	GT	U4		GT	U2	N3	U4	ļ	<u> </u>		GT		ode 96	act with	2009, 3 s of the	ind inte	ested in	uth's re		h's mec g., diab		//caregi	sponsi	s, blood	medica	and as	opriate I	nd refer	likely t s as a p	oms the
rvices		T1002	T1003		T1003	96156	96156	96156		96156		96156		iter for CPT o	to-face conta	actice Act of	sessments a	crises manife	toring the yo	n review;	toring a yout condition (e.		outh's family	and family/re	nt gain or los	inistration of	ed to monitor	red by appro	nt, testing, aı	oms that are	strate sympti ling condition
Nursing Assessment and Health Services	Practitioner Level 2, Via	interactive audio and video telecommunication systems	Practitioner Level 4, In-Clinic	Practitioner Level 4, Via	interactive audio and video telecommunication systems	Practitioner Level 2, In-Clinic	Practitioner Level 3, In-Clinic	Practitioner Level 4, In-Clinic	Practitioner Level 2, Via	interactive audio and video	Practitioner Level 3. Via	interactive audio and video	telecommunication systems	15 minutes for T codes, 1 encounter for CPT code 96156	 This service requires face- 	pursuant to the Medical Practice Act of 2009, Subsection 43-34-2 pursuant to the medical Practice Act of 2009, Subsection 43-34-2 physical problems and general wellness of the volute.	a. Providing nursing as:	issues, problems or crises manifested in the course of the youth's treatment;	b. Assessing and monit	youth for a medication review;	 Assessing and monitoring a youth's medical and the treatment of the condition (e.g., diabetes) 		d. Consulting with the y issues.	e. Educating the youth			h. Venipuncture required to monitor and assess	medications, as ordered by appropriate members of the medical staff; and	 Providing assessment, testing, and referral for infectious diseases. 	 Youth presents with symptoms that are likely to respond to medical/nursing interventions; or Youth has been prescribed medications as a part of the treatment/service array or has a con 	
g Asse					utes	havior int or				_	ns,	cision		<i>a</i>																	
Nursin				LPN Services,	up to 15 min	Health Behavior	Re-assessment	(e.g., health-	focused clinical	interview, behavioral	observations,	clinical decision	making)	Unit Value							0	Definition								Admission Criteria	Continuing Stay Criteria

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	.ved.	Case	1:16	6-cv-	ietician	ndicated or if	Docur	1	448-73 esn sns.eo	Filled :	
Nursing Assessment and Health Services	3. Youth demonstrates progress relative to medical/medication goals identified in the Individualized Resiliency Plan, but goals have not yet been achieved.	 An adequate continuing care plan has been established; and one or more of the following: Youth no longer demonstrates symptoms that are likely to respond to or are responding to medical/nursing interventions; or Goals of the Individualized Resiliency Plan have been substantially met; or Youth/family requests discharge and youth is not in imminent danger of harm to self or others. 	Medication Administration, Opioid Maintenance.	Routine nursing activities that are included as a part of ambulatory detoxification and medication administration/methadone administration.	1. Nutritional assessments indicated by a youth's confounding health issues might be billed under this code (96150, 96151). No more than 8 units specific to nutritional assessments can be billed for an individual within a year. This specific assessment must be provided by a Registered Nurse or by a Licensed Dietician	 (LD). This service does not include the supervision of self-administration of medication. This service does not include the supervision of self-administration of medication. Each nursing contact should document the checking of vital signs (Temperature, Pulse, Blood Pressure, Respiratory Rate, and weight, if medically indicated or if related to behavioral health symptom or behavioral health medication side effect) in accordance with general psychiatric nursing practice. 		To promote access, providers may use Telemedicine as a tool to provide direct interventions to individuals for whom English is not their first language. Examples of this include:	 the use of one-to-one service intervention via Telemedicine, connecting the individual to a practitioner who speaks the individual's language versus use of interpreters; and/or the use of an interpreter via Telemedicine to support the practitioner in delivering the identified service. 	Telemedicine may only be utilized when delivering this service to an individual for whom English is not their first language. The individual/family must consent to the use of this modality. This consent should be documented in the individual's record. The use of telemedicine should <u>not</u> be driven by the practitioner's/agency's convenience or preference.	1. If a Medicaid claim for this service denies for a Procedure-to-Procedure edit, a modifier (59) can be added to the claim and resubmitted to the MMIS for payment. 2. When Telemodicine technology is utilized for the provision of this control.
Nursing Ass		Discharge Criteria	Service Exclusions	Clinical Exclusions		Required Components	Clinical Operations		Service Accessibility		Billing &

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Pharmacy and Lab	nd Lab	
Continuing Stay Criteria	Individual continues to meet the admission criteria as determined by the prescribing professional.	
Discharge Criteria	1. Individual no longer demonstrates symptoms that are likely to respond to or are responding to pharmacologic interventions; or 2. Individual requests discharge and individual is not imminently demonstrate out or under for this intervention.	
	1. Service must be provided by a licensed pharmacy or through contract with a licensed pharmacy.	Ca
Required	2. Agency must participate in any pharmaceutical rebate programs or pharmacy assistance programs that promote individual access in obtaining medication.	se
Components	3. Providers shall refer all individuals who have an inability to pay for medications or services to the local county offices of the Division of Family and Children	1::
	Services for the purposes of determining Medicaid eligibility.	16
Additional Medicaid	Not a DBHDD Medicaid service. Medicaid recipients may access the general Medicaid pharmacy program as prescribed by the Department of Community Health.	6-cv-
Requirements		03
		088-E
Psychiatric Treatment	Treatment	ELR

Psychiatric Treatment	c Tre	atment													
Transaction Code	əpc	Code Detail	Code	Mod 1	Mod 2	Mod N 3	Mod Rate 4		Code Detail	Code	Mod 1	Mod 2	Mod 3	Mod 4	Rate
		Practitioner Level 1, In-Clinic	99202	11	90		97.	97.00 Pr	Practitioner Level 2, In-Clinic	99202	N2	90			64.95
	15 – 29 minutes	Practitioner Level 1, Out-of-Clinic	99202	L1	U2		123.50		Practitioner Level 2, Out-of-Clinic	99202	N2	17			77.95
	Spinings	Practitioner Level 1	99202	GT	L)		97.00		Practitioner Level 2	99202	GT	U2			64.95
	:	Practitioner Level 1, In-Clinic	99203	U1	90		155.20		Practitioner Level 2, In-Clinic	99203	U2	90			103.92
Š	30 – 44 minutes	Practitioner Level 1, Out-of-Clinic	99203	IJ	U7		197.60		Practitioner Level 2, Out-of-Clinic	99203	N2	17			124.72
E/M	Spinings	Practitioner Level 1	99203	GT	L)		155.20		Practitioner Level 2	99203	GT	U2			103.92
New Dationt	1	Practitioner Level 1, In-Clinic	99204	LI	90		213.40		Practitioner Level 2, In-Clinic	99204	N2	9N			142.89
	45 - 59 minites	Practitioner Level 1, Out-of-Clinic	99204	11	U2		271.70		Practitioner Level 2, Out-of-Clinic	99204	U2	U2			171.49
	200	Practitioner Level 1	99204	19	U1		213.40		Practitioner Level 2	99204	GT	U2			142.89
		Practitioner Level 1, In-Clinic	99205	11	90		271.60		Practitioner Level 2, In-Clinic	99205	U2	9N			181.86
	60 – 74 minites	Practitioner Level 1, Out-of-Clinic	99205	N1	U2		345.80		Practitioner Level 2, Out-of-Clinic	99205	U2	17			218.26
		Practitioner Level 1	99205	LS	U1		271.60		Practitioner Level 2	99205	GT	U2			181.86
	ı	Practitioner Level 1, In-Clinic	99211	N1	9N		19.40		Practitioner Level 2, In-Clinic	99211	U2	90			12.99
	~ 5 minites	Practitioner Level 1, Out-of-Clinic	99211	IN	U7		24.70		Practitioner Level 2, Out-of-Clinic	99211	U2	10			15.59
		Practitioner Level 1	99211	LS	U1		19.	19.40 Pr	Practitioner Level 2	99211	GT	U2			12.99
		Practitioner Level 1, In-Clinic	99212	N1	9N		58.20		Practitioner Level 2, In-Clinic	99212	U2	90			38.97
į	10 - 19 minites	Practitioner Level 1, Out-of-Clinic	99212	U1	U7		74.10		Practitioner Level 2, Out-of-Clinic	99212	U2	U7			46.77
E/M		Practitioner Level 1	99212	19	U1		58.	58.20 Pr	Practitioner Level 2	99212	GT	U2			38.97
Established Dotiont	0	Practitioner Level 1, In-Clinic	99213	N1	90		97.00		Practitioner Level 2, In-Clinic	99213	U2	Ole			64.95
רמוופווו	20 - 29 minimes	Practitioner Level 1, Out-of-Clinic	99213	U1	U7		123.50		Practitioner Level 2, Out-of-Clinic	99213	U2	U7			77.95
		Practitioner Level 1	99213	GT	U1		97.00		Practitioner Level 2	99213	GT	U2			64.95
	30 - 39	Practitioner Level 1, In-Clinic	99214	1	90		135.80		Practitioner Level 2, In-Clinic	99214	N2	90			90.93
	minutes	Practitioner Level 1, Out-of-Clinic	99214	N1	U2		172.90		Practitioner Level 2, Out-of-Clinic	99214	U2	U2			109.13

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- (5)	Psychiatric Treatment	-					<u>-</u>				
Practitioner Level 1	Practitioner Level 1	99214 G	E GT	101	135.80	Practitioner Level 2	99214	E GT	UZ	90.93	
Practitione	Practitioner Level 1, Out-of-Clinic	+ +	11		247.00	Practitioner Level 2, Out-of-Clinic	99215	70		т т	(
Practitio	Practitioner Level 1	99215 G	GT :		194.00	Practitioner Level 2	99215	GT	U2	129.90	Ca
1 enco	1 encounter (Note: Time-in/Time-out is required in the documentation as it justifies which code above is billed)	ıt is required	in the	documentation as it ju	stifies	Utilization Criteria	TBD				se 1
The pl a. b. c.	The provision of specialized medical and/or psychiatric services that include, but are not limited to: a. Psychotherapeutic services with medical evaluation and management including evaluation morbidity between behavioral and physical health care issues); b. Assessment and monitoring of an individual's status in relation to treatment with medication c. Assessment of the appropriateness of initiating or continuing services.	sal and/or ps se with medie oral and phy og of an indie riateness of	sychia cal ev sical l vidual' initiat	ric services that include, but are not limited to: aluation and management including evaluation a lealth care issues); status in relation to treatment with medication; ing or continuing services.	de, but a nent incl treatmer ices.	vision of specialized medical and/or psychiatric services that include, but are not limited to: Psychotherapeutic services with medical evaluation and management including evaluation and assessment of physiological phenomena (including comorbidity between behavioral and physical health care issues); Assessment and monitoring of an individual's status in relation to treatment with medication; Assessment of the appropriateness of initiating or continuing services.	of physiolog	gical pł	nenomena (including c		L:16-cv-0308
Youtl Subs and t	Youth must receive appropriate medical interventions Subsection 43-34-23 Delegation of Authority to Nurse and their parent/guardians and their Individualized Re	edical interv f Authority to ir Individuali	ention 5 Nurs ized R	s as prescribed and pe and pe and Physician Assi e and Physician Assi ecovery Plan (within	rovided stant tha the para	as prescribed and provided by members of the medical staff pursuant to the Medical Practice Act of 2009, and Physician Assistant that shall support the individualized goals of recovery as identified by the individual covery Plan (within the parameters of the youth/family's informed consent).	ursuant to the sals of reco	ne Mec very as very as	iical Practice Act of 20 s identified by the indiv		8-ELR
Note	: For the purposes of this mar	ıual, Psychi	atric T	reatment is sometime	s referre	Note: For the purposes of this manual, Psychiatric Treatment is sometimes referred to as "physician assessment" or "physician assessment and care."	"physician	assess	ment and care."		Do
1. 1	Individual is determined to be in need of psychotherapy services and has comedical oversight; or Individual has been prescribed medications as a part of the treatment array.	in need of promed in medication.	sycho s as a	herapy services and part of the treatment	has conf array.	erapy services and has confounding medical issues which interact with behavioral health diagnosis, requiring bart of the treatment array.	act with be	haviora	al health diagnosis, rec		cumen
5. 6. 4. 7.	Individual continues to meet the admission criteria; or Individual exhibits acute disabling conditions of sufficient severity to bring about a significant impairment Individual continues to present symptoms that are likely to respond to pharmacological interventions; or Individual continues to demonstrate symptoms that are likely to respond or are responding to medical in Individual continues to require management of pharmacological treatment in order to maintain symptom	ing condition symptoms strate sympt	ns of a that an come the come come come come come come come com	ia; or sufficient severity to b e likely to respond to nat are likely to respo harmacological treatr	ring abou pharmao nd or are	Individual continues to meet the admission criteria; or Individual exhibits acute disabling conditions of sufficient severity to bring about a significant impairment in day-to-day functioning; or Individual continues to present symptoms that are likely to respond to pharmacological interventions; or Individual continues to demonstrate symptoms that are likely to respond or are responding to medical interventions; or Individual continues to require management of pharmacological treatment in order to maintain symptom remission.	o-day functi ns; or n.	oning;	or		t 448-73
- . ഗ ფ	An adequate continuing care plan has been established; and one or more of the following: Individual has withdrawn or been discharged from service; or Individual no longer demonstrates symptoms that need pharmacological interventions.	olan has bee en discharg tes symptor	ed fro	blished; and one or more of the follom service; or the macological interventions.	more of	the following: rentions.					Filed 1
2 %	Not offered in conjunction with ACT. Supervision time is not billable. Time spent on documentation is not billable.	ACT.	o.								1/29/23
Ser	Services defined as a part of ACT.										3
Whe	When providing psychiatric services to individuals who are deaf, deaf-blind, and/or hard of consultation with a qualified professional as approved by DBHDD Office of Deaf Services.	s to individusional as as	Jals w	ho are deaf, deaf-blin d by DBHDD Office c	d, and/or if Deaf S	When providing psychiatric services to individuals who are deaf, deaf-blind, and/or hard of hearing, psychiatrists shall demonstrate training, supervision, or consultation with a qualified professional as approved by DBHDD Office of Deaf Services.	l demonstra	ate trai	ning, supervision, or		Page
- 11 3 3 3	n accordance with recovery phas such, it is expected that prace treatment options should incluc effects, potential adverse react discussion/disclosure is not por including the specific information.	illosophy, it ctitioners wi le a full disc ions - includ issible or adv	is exp ill fully losure ling pc //sable not di	ected that individuals discuss treatment op of the pros and consortential adverse reacting to the clin scussed and a composition of the clin	will be tr tions with of each on from I ical judgi	1. In accordance with recovery philosophy, it is expected that individuals will be treated as full partners in the treatment regimen/services planned and received. As such, it is expected that practitioners will fully discuss treatment options with individuals and allow for individual choice when possible. Discussion of treatment options should include a full disclosure of the pros and cons of each option (e.g., full disclosure of medication/treatment regimen potential side effects, potential adverse reactions - including potential adverse reaction from not taking medication as prescribed and expected benefits). If such full discussion/disclosure is not possible or advisable according to the clinical judgment of the practitioner, this should be documented in the individual's chart (including the specific information that was not discussed and a compelling rationale for lack of discussion/disclosure).	ent regimer Il choice wh cation/treat d and exper I be docum ure).	n/servir	ces planned and receissible. Discussion of egimen potential side snefits). If such full in the individual's charm		52 of 627

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nent	
tric Treatr	
Psychia	

	2. Assistive tools, technologies, worksheets, etc. can be used by the served individual to facilitate communication about treatment, symptoms, improvements, etc.
	with the treating practitioner. If this work falls into the scope of Interactive Complexity, it is noted in accordance with that definition.
	3. This service may be provided with Individual Counseling codes 90833 and 90836, but the two services must be separately identifiable.
	4. For purposes of this definition, a "new patient" is an individual who has not received an E/M code service from that agency within the past three (3) years. If an
	individual has engaged with the agency and has seen a non-physician for a BH Assessment, they are still considered a "new patient" until after the first E/M
	service is completed.
Convice Accessibility	This service may be provided via telemedicine to any individual/family who consents to this modality. This consent should be documented in the individual's
Oct vice Accessionity	record. The use of telemedicine should not be driven by the practitioner's/agency's convenience or preference.
4.00.14.14.14.14.14.14.14.14.14.14.14.14.14.	1. The daily maximum within a CSU for E/M is 1 unit/day.
Pogniromonte	2. Even if a physician also has his/her own Medicaid number, the physician providing behavioral health treatment and care through this code should bill via the
בשלמוו פווופוווס	approved provider agency's Medicaid number through the Medicaid Category of Service (COS) 440.
	1. Within this service group, a second unit with a U1 modifier may be used in the event that a Telemedicine Psychiatric Treatment unit is provided and it indicates
	a need for a face-to-face assessment (e.g. 99213GTU1 is billed and it is clinically indicated that a face-to-face by an on-site physician needs to immediately
	follow based upon clinical indicators during the first intervention, then 99213U1, can also be billed in the same day).
	2. Within this service group, there is an allowance for when a U2 practitioner conducts an intervention and, because of clinical indicators presenting during this
	intervention, a U1 practitioner needs to provide another unit due to the concern of the U2 supervisee (e.g., Physician's Assistant provides and bills 90805U2U6
Dilling 0 Doodling	and because of concerns, requests U1 intervention following his/her billing of U2 intervention). The use of this practice should be rare and will be subject to
Dealifements	additional utilization review scrutiny.
Ned all all all s	3. These E/M codes are based upon Time (even though recent CPT guidance allows the option of using either Medical Decision Making or Time). The Georgia
	Medicaid State Plan is priced on time increments and therefore time will remain the basis of justification for the selection of codes above for the near term.
	4. If a Medicaid claim for this service denies for a Procedure-to-Procedure edit, a modifier (25) can be added to the claim and resubmitted to the MMIS for
	payment.
	5. Despite recent CPT guidance, this service may not be billed for all time spent on an individual's case in a single day (i.e. pre- and post-appointment work that is
	not direct individual assessment and/or care), because this indirect time is already included in the service rate.

Psychological 1	esting: Psychological Te	sting – P	sycho	-diagn	ostic as	sessm	nent of el	Psychological Testing: Psychological Testing – Psycho-diagnostic assessment of emotionality, intellectual abilities, personality and psycho-pathology	persona	lity an	d psyck	ο-patho	ogy
Transaction Code	Code Detail	Code	Mod 1	Mod 2	ModModModRate234	Mod 4	Rate	Code Detail	Code	Mod 1	Mod 2	Code Mod Mod Mod Rate	d Rate
Psychological testing evaluation services by physician or other qualified health care professional, including integration of patient data, integration of the profession of th	Practitioner Level 2, In-Clinic 96130	96130	UZ	90		O3	155.87	\$155.87 Practitioner Level 2, Out-of-Clinic	96130 U2		U7		\$187.04
standards dest results and clinical data, clinical decision making, treatment planning and report and interactive feedback to the patient, family member(s) or caregiver(s), when performed; first hour	Practitioner Level 2, Via interactive audio and video telecommunication systems	96130	GT	U2		,	155.87						
Each additional hour (List separately in addition to code for primary procedure)	Practitioner Level 2, In-Clinic 96131 U2	96131	U2	9N		0,7	155.87	\$155.87 Practitioner Level 2, Out-of-Clinic	96131 U2 U7	U2	U7		\$187.04

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Psychological ⁻	Psychological Testing: Psychological Testing – Psycho-diagn	sting – F	Psvcho		stic asses:	sment of e	ostic assessment of emotionality, intellectual abilities, personality and psycho-pathology	persona	ality an	d psycho-pathol	Λbc	
	Practitioner Level 2, Via interactive audio and video telecommunication systems	96131	GT			155.87			,	- -	3	
Psychological or neuropsychological test	Practitioner Level 2, In-Clinic	96136	U2	90		\$77.94	Practitioner Level 2, Out-of-Clinic	96136	U2	70	\$93.52	Cas
administration and scoring by physician or other qualified health care professional, any method, first 30 minutes	Practitioner Level 2, Via interactive audio and video telecommunication systems	96136	GT	U2		\$77.94						se 1:16-
ارد احدد الارداد المديد المادد الم	Practitioner Level 2, In-Clinic	96137	U2	90		\$77.94	Practitioner Level 2, Out-of-Clinic	96137	U2	107	\$93.52	cv-0
Each additiona 30 minutes (List separately in addition to code for primary procedure)	Practitioner Level 2, Via interactive audio and video telecommunication systems	96137	GT	U2		\$77.94)3088-E
	Practitioner Level 3, In-Clinic	96138	U3	9N		\$60.02	Practitioner Level 4, In-Clinic	96138	U4	9N	\$40.59	ELR
Psychological or neuropsychological test administration and scoring by	Practitioner Level 3, Out-of- Clinic	96138	U3	107		\$73.36	Practitioner Level 4, Out-of-Clinic	96138	U4	70	\$48.71	D
technician, any method; first 30 minutes	Practitioner Level 3, Via interactive audio and video telecommunication systems	96138	GT	U3		\$60.02	Practitioner Level 4, Via interactive audio and video telecommunication systems	96138	GT	U4	\$40.59	ocume
	Practitioner Level 3, In-Clinic	96139	U3	90		\$60.02	Practitioner Level 4, In-Clinic	96139	U4	9N	\$40.59	nt 4
Each additional 30 minutes (List separately in addition to code for primary procedure-	Practitioner Level 3, Out-of- Clinic	96139	U3	107		\$73.36	Practitioner Level 4, Out-of-Clinic	96139	V4	U7	\$48.71	48-73
96138)	Practitioner Level 3, Via interactive audio and video telecommunication systems	96139	GT	n3		\$60.02	Practitioner Level 4, Via interactive audio and video telecommunication systems	96139	GT	4O	\$40.59	Filed
Unit Value	1 hour or 30 minutes						Utilization Criteria	TBD				1
	Psychological testing consists of intellectual abilities using an objective interpretation of results is based.	s of a face objective a sed.	e-to-face	e assessi ndardizec	nent of emo tool that ha	otional funct as uniform p	Psychological testing consists of a face-to-face assessment of emotional functioning, personality, cognitive functioning (e.g., thinking, attention, memory) or intellectual abilities using an objective and standardized tool that has uniform procedures for administration and scoring and utilizes normative data upon which interpretation of results is based.	ning (e.g., oring and	thinkin utilizes	g, attention, memo normative data up	ry) or on which	1/29/23
Service Definition	Psychological tests are only a test ensures that the testing e of privacy and confidentiality.	administer environme	ed and	interpret not inter	ed by those fere with th	who are pr e performar	Psychological tests are only administered and interpreted by those who are properly trained in their selection and application. The practitioner administering the test ensures that the testing environment does not interfere with the performance of the examinee and ensures that the environment affords adequate protections of privacy and confidentiality.	applicatior it the envi	. The pronumen	ractitioner adminis t affords adequate	tering the protections	Page 5
	This service covers both the I (with the proper education an	face-to-fac	se admi) interpr	nistratior eting the	of the test test results	instrument(and prepar	This service covers both the face-to-face administration of the test instrument(s) by a qualified examiner as well as the time spent by a psychologist or physician (with the proper education and training) interpreting the test results and preparing a written report in accordance with CPT procedural guidance.	the time th CPT pr	spent by	y a psychologist or al guidance.	physician	54 of (
Admission Criteria	A known or suspected mental illness or substance-related disorder; and Initial screening/intake information indicates a need for additional undeted Individual meets DBHDD eligibility.	nental illne Iformation) eligibility.	ss or su indicate	abstance es a need	related disc d for additio	order; and nal undeten	A known or suspected mental illness or substance-related disorder; and Initial screening/intake information indicates a need for additional undetermined supports and recovery/resiliency planning; and Individual meets DBHDD eligibility.	ıcy planni	ng; and			627

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Psychological 1	Psychological Testing: Psychological Testing – Psycho-diagnostic assessment of emotionality, intellectual abilities, personality and psycho-pathology
Continuing Stay Criteria	The Individual's situation/functioning has changed in such a way that previous assessments are outdated.
Discharge Criteria	Each intervention is intended to be a discrete time-limited service that modifies treatment/support goals or is indicated due to change in illness/disorder.
Staffing Requirements	The term "psychologist" is defined in the Approved Behavioral Health Practitioners table in Section II of this manual (Reference § 43-39-1 and § 43-39-7).
Required Components	 There may be no more than 10 combined hours of the codes above provided to one individual within an authorization. When providing psychological testing to individuals who are deaf, deaf-blind, or hard of hearing, practitioner shall demonstrate training, supervision, and/or consultation with a qualified professional as approved by DBHDD Office of Deaf Services.
Clinical Operations	The individual (and caregiver/responsible family members etc. as appropriate) must actively participate in the assessment processes.
Documentation Requirements	In addition to the authorization produced through this service, documentation of clinical assessment findings from this service should also be completed and placed in the individual's chart.
	To promote access, providers may use Telemedicine as a tool to provide direct interventions to individuals for whom English is not their first language. Examples of this include:
	• the use of one-to-one service intervention via Telemedicine, connecting the individual to a practitioner who speaks the individual's language versus use of interpreters; and/or
Service Accessibility	 the use of an interpreter via Telemedicine to support the practitioner in delivering the identified service.
	Telemedicine may only be utilized when delivering this service to an individual for whom English is not their first language. The individual/family must consent to the use of this modality. This consent should be documented in the individual's record. The use of telemedicine should not be driven by the practitioner's/agency's convenience or preference.
	 Each unique code cannot be billed more than 5 units on a single day. Add-on codes shall be provided on the same day as the associated base code). Scoring may occur and be billed on a different day than the evaluation and testing procedures (and related codes).
Billing & Reporting Requirements	4 If a Medicaid claim for this service denies for a Procedure-to-Procedure edit, a modifier (59) can be added to the claim and resubmitted to the MMIS for
	Fayment. 5. When Telemedicine technology is utilized for the provision of this service in accordance with the allowance in the Service Accessibility section of this definition, the code cited in the Code Detail above with the appropriate GT modifier shall be utilized in documentation and claims submission.

Service Plan	Service Plan Development													
Transaction	Code Detail	Code	Mod	Mod Mod Mod Rate	Mod	Mod		Code Detail	Code Mod Mod Mod Mod Rate	Mod	Mod	Mod	Mod	Rate
Code			1	2	3	4				1	2	3	4	
	Practitioner Level 2, In-Clinic	H0032 U2	U2	90			\$38.97	\$38.97 Practitioner Level 2, Out-of-Clinic H0032 U2	H0032	U2	U2			\$46.76
	Practitioner Level 3, In-Clinic	H0032 U3	U3	90			\$30.01	\$30.01 Practitioner Level 3, Out-of-Clinic H0032 U3	H0032	N3	U7			\$36.68
Service Dlan	Practitioner Level 4, In-Clinic	H0032 U4	U4	90			\$20.30	\$20.30 Practitioner Level 4, Out-of-Clinic H0032 U4	H0032	U4	U2			\$24.36
Develonment	Practitioner Level 5, In-Clinic	H0032 U5	U5	90			\$15.13	\$15.13 Practitioner Level 5, Out-of-Clinic	H0032 U5	U5	U2			\$18.15
	Practitioner Level 2, Via interactive							Practitioner Level 4, Via						
	audio and video telecommunication	H0032	GT	U2			38.97	interactive audio and video	H0032 GT U4	GT	4			20.30
	systems							telecommunication systems						

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	Service Plan Develonment
	Practitioner Level 3, Via interactive
	audio and video telecommunication H0032 GT U3 30.01 interactive audio and video H0032 GT U5 15.13 systems
\perp	es
	Youth/Families access this service when it has been determined through an initial screening that the youth has mental health or substance use disorder concerns. The Individualized Recovery/Resiliency Plan (IRP) results from the Diagnostic and Behavioral Health Assessments and is required within the first 30 days of service, with ongoing plans completed as demanded by individual need and/or by service policy.
	Information from a comprehensive assessment should ultimately be used to develop, together with the youth and/or caretakers an IRP that supports resilience and that is based on goals identified by the individual with parent(s)/responsible caregiver(s) involvement. As indicated, medical, nursing, peer, school, nutritional, etc. staff should provide information from records, and various multi-disciplinary assessments for the development of the IRP.
	The comerstone component of the youth IRP involves a discussion with the child/adolescent and parent(s)/responsible caregiver(s) regarding what resiliency means to them personally (e.g., the youth having more friends, improvement of behavioral health symptoms, staying in school, improved family relationships etc.), and the development of goals (i.e. outcomes) and objectives that are defined by and meaningful to the youth based upon the individual's articulation of their recovery hopes. Concurrent with the development of the IRP, an individualized safety plan should also be developed, with the individual youth and parent(s)/responsible caregiver(s) guiding the process through the free expression of their wishes and through their assessment of the components developed for the safety plan as being realistic for them. The entire process should involve the youth as a full partner and should focus on service and resiliency goals/outcomes as identified by the youth and his/her family as well as collateral agencies/treatment providers/relevant individuals.
	 Recovery/Resiliency planning shall set forth the course of care by: Prioritizing problems and needs; Stating goals which will honor achievement of stated hopes, choice, preferences and desired outcomes of the youth/family; Assuring goals/objectives are related to the assessment; Defining goals/objectives that are individualized, specific, and measurable with achievable timeframes; Defining discharge criteria and desired changes in levels of functioning and quality of life to objectively measure progress; Transition planning at onset of service delivery; Selecting services and interventions of the right duration, intensity, and frequency to best accomplish these objectives; Assuring there is a goal/objective that is consistent with the service intent; and Identifying qualified staff who are responsible and designated for the provision of services.
	 A known or suspected mental illness or substance-related disorder; and Initial screening/intake information indicates a need for additional undetermined supports and recovery/resiliency planning; and Youth meets DBHDD eligibility.
	The youth's situation/functioning has changed in such a way that previous assessments are outdated.
	Each intervention is intended to be a discrete time-limited service that modifies treatment/support goals or is indicated due to change in illness/disorder.
	1. The service plan must include elements articulated in the Community Requirements chapter in this Provider Manual. 2. As indicated, medical, nursing, peer, school, nutritional, etc. staff can provide information from the youth and family, records, and various multi-disciplinary resources needed to complete the service plan. Time spent gathering this information may be billed as long as the detailed documentation justifies the time and need for capturing said information.
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vervice Plan	Service Plan Development	
	1. The individual (and caregiver/responsible family members etc. as appropriate) should actively participate in planning processes.	
	2. The Individualized Resiliency Plan should be directed by the individual's/family's personal resiliency goals as defined by them.	
	3. Safety/crisis planning should be directed by the youth/family and their needs/wishes to the extent possible and clinically appropriate. Plans should not contain	
	elements/components that are not agreeable to, meaningful for, or realistic for the youth/family and that the youth/family is therefore not likely to follow through	(
	with.	Ca
Clinical	4. Detailed guidelines for recovery/resiliency planning are contained in the "Community Requirements" in this Provider Manual and must be adhered to.	se
Operations	5. For youth at or above age 17 who may need long-term behavioral health supports, plan elements should include transitional elements related to post-primary	1:
	education, adult services, employment (supported or	16
	6. Individualized Recovery/Resiliency Plans (or portions of the plan) must be reassessed as needed, in accordance with changing needs, circumstances, and	6-C
	responses of the youth and family/caregiver (see content regarding the IRP in Part II of this manual). For any change in medical, behavioral, cognitive, and/or	:V-
	physical status of the youth that potentially impacts goals, objectives and/or interventions in the plan, or that would necessitate the addition of new goals,	03
	objectives and/or interventions, Service Plan Development would be used to support the youth and family/caregiver in revisiting their goals and objectives.	80
	To promote access, providers may use Telemedicine as a tool to provide direct interventions to individuals for whom English is not their first language. Examples of this	8-
	include:	EL
	• the use of one-to-one service intervention via Telemedicine, connecting the individual to a practitioner who speaks the individual's language versus use	.R
Service	of interpreters; and/or	
Accessibility	 the use of an interpreter via Telemedicine to support the practitioner in delivering the identified service. 	Do
	Telemedicine may only be utilized when delivering this service to an individual for whom English is not their first language. The individual/family must consent to the	cur
	use of this modality. This consent should be documented in the individual's record. The use of telemedicine should not be driven by the practitioner's agency's	ne
	convenience or preference.	nt -
Billing &	When Telemedicine technology is utilized for the provision of this service in accordance with the allowance in the Service Accessibility section of this definition, the	448
Requirements	code cited in the Code Detail above with the appropriate GT modifier shall be utilized in documentation and claims submission.	3-73
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CHILD and ADOLESCENT SPECIALTY SERVICES

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	Rate		a ate.	
			utilizes the sta	
	Moc 4		gram u ughout	
	Mod 3		he pro e) thro	
	Mod Mod Mod Mod		rricts. T	
	Mod 1		ool disi ugh 12 ool sett	
	Code		nd local sch (Pre-K thro public sch	
	Code Detail	See Billing & Reporting Requirements section below for services billing detail.	ed behavioral health providers ar vices among school-aged youth of DBHDD services in designated	; scents; and
	Rate	section belo	munity-base al health ser provision o	ealth needs and adoles
	Mod 4	ments	en com thaviora for the	vioral h
	Mod Mod Mod 2 3 4	equire	betweeds to be support	it behaves
	Mod 2	orting F	nership e acces djunct	olescer servic
	Mod 1	& Repo	ed parti increas s and a	and ad
ا (۳	Code	See Billing	BHDD-funde mework to i interventions	ion of child a
Apex Program (Georgia Apex Program)	Code Detail		The Georgia Apex Program is a DBHDD-funded partnership between community-based behavioral health providers and local school districts. The program utilizes a school-based behavioral health framework to increase access to behavioral health services among school-aged youth (Pre-K through 12th grade) throughout the state. The Program provides preventive interventions and adjunct support for the provision of DBHDD services in designated public school settings.	Apex Program Goals: 1. Prevention and early detection of child and adolescent behavioral health needs; 2. Increase statewide access to behavioral health services for children and adolescents; and
Apex Progra	Transaction Code		Service	Definition

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Apex Progra	Apex Program (Georgia Apex Program) 3. Encourage sustainable coordination between Georgia's community behavioral health providers and their local schools/school districts.	
	The Apex Program helps to support program development, relationship building, and embedding providers in schools, and aligns with other types of school-based behavioral health support programs such as Positive Behavioral Interventions and Supports. The Program utilizes a Multi-Tiered System of Support (MTSS) framework for delivering services to students, and while providers implement services across all three tiers, they prioritize delivering services to youth represented in MTSS Tier III.	Case
	MTSS Tier I interventions promote universal prevention benefiting the entire school. MTSS Tier II refers to targeted early interventions for at-risk students with emerging behavioral health needs. MTSS Tier III refers to individualized intervention for students identified as living with a behavioral health diagnosis.	e 1:16-cv-
	s facilitate l). In behavioral school and reeting and	03088-ELR
	comerence attendance, trainings, individual teacher-based needs assessmenteducation/skill building regarding benavioral neatth conditions and classroom interventions, and other related activities.	Doc
	Specific allowable DBHDD behavioral health services (see the Service Definition/Requirements for each service listed below in this Provider Manual): 1. Behavioral Health Assessment; 2. Diagnostic Assessment:	ument
	Service Plan Development; Crisis Intervention:	448-
		73
	Group Counseling; Family Counseling/Training;	Fi
		led
	Medication Administration; and Mureing Accessment and Health Services	11/2
	Youth must be enrolled in a designated public school setting; and	9/2:
Admission	omer criteria for child and adolescent services in the DBHDD's Provider Manual for Community Based Behavioral Health	3
Ollena	Troviders, Part 1, Section 1, and 3. The youth's level of functioning does not preclude the provision of services in an outpatient milieu.	Pa
Continuing Stay Criteria	ery Plan, but goals have either not yet been achieved, or new	.ge 58
Discharge		of 627
Cliffina	Tourn or uneil parentriegar guardian requests that the youth no longer participate in the Apex Program and/or associated DBnDD behavioral nearth services, or Transfer to another service is warranted due to a change in the youth's condition and/or needs.	,

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9 % = 3	 The Apex Program may only be implemented in designated public school settings. The Apex Program may only be implemented in designated public school settings. The Apex Program is administered by approved DBHDD service providers (Where these exist). DBHDD services provided via the Apex Program must adhere to all DBHDD service definitions and requirements for each service provided. Each Apex Program provider must have an established referral process, which is documented in the Provider's internal Policies and Procedures. Each Apex Program must be offered year-round, including during the summer. Providers must obtain and maintain commitment by the school leadership to support school based behavioral health services (e.g., designated space for treatment and confidential file storage, communication plan for parents and teachers to announce and coordinate the implementation of services, evidence that student support professionals support the new service and will collaborate with the mental health professionals including professional school counselors, support teams and response to intervention teams, natural supports, physician; school student support professionals including professionals school counselors, school nurses; or Local Interagency Planning Teams [LIPTs]). 	 One FTE Apex Program Coordinator; Provider must adhere to the Staffing Requirements section of the Service Definition/Requirements for the specific DBHDD service being provided, as well as to all other staffing/professional requirements found elsewhere in the DBHDD's Provider Manual for Community Based Behavioral Health Providers; Supervisees/trainees must work alongside a practitioner who is independently licensed while inside the school. 	 The Program encourages access to behavioral health services for youth and families who may otherwise not become engaged due to externalities such as transportation challenges, parental work schedules, etc. In addition, this program is offered in a school-based setting in order to identify and engage with youth in a familiar environment where they spend much of their time. DBHDD behavioral health services may be provided via telemedicine as may be allowable per the Service Definition/Requirements for each particular service. 	 Provider must adhere to the Documentation Requirements section of the Service Definition/Requirements for the specific DBHDD service being provided, as well as to Part II, Section III of the DBHDD's Provider Manual for Community Based Behavioral Health Providers. For services provided/activities engaged in as part of the Apex Program, but which are not defined DBHDD behavioral health services (e.g. travel, conference attendance, meetings with school/community stakeholders, etc.), provider must meet the documentation requirements established through the Georgia State COE evaluation process, as well as DBHDD's monthly progress report process. 	 DBHDD service provision, billing, and reporting must adhere to all DBHDD and Georgia Collaborative ASO requirements. Provider must submit a monthly invoice, and invoice justification/supporting documentation (as needed) to their designated DBHDD contract manager. Providers are required to maximize utilization of alternative funding streams, including third party payers (e.g., Medicaid, private insurance, etc.), public targeted and competitive grants, and private foundation funds. 	 To promote program sustainability, a target threshold of sixty percent (60%) billable direct-service time per clinical staff member has been established, and providers should make a good faith effort to reach this target as quickly and efficiently as possible. However, during the first contract-term of service provision, staff are required to meet a minimum threshold of forty percent (40%) billable time. Apex may also provide up to 60 days of reimbursement for DBHDD services delivered by Tier 2 providers who cannot bill DBHDD state-funds for uninsured individuals served. Outpatient services that are identified in the service definition above may be authorized and billed in accordance with Part I, Section II of this manual via the Non-intensive Outpatient Services Type of Care.
ogra	v)	ıts		ion ts		ıts
Apex Pr Clinical Exclusions	Required Components	Staffing Requirements	Program Accessibility	Documentation Requirements		Billing & Reporting Requirements

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e asnou	use services (Release 1DD)													
action	Code Detail	Code	Mod	Mod	Mod	Mod	Rate	Code Detail	Code	Mod	Mod	Mod	Mod	Rate
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Community	Community Based Inpatient Psychiatric and Substance Detoxification	
Transaction Code	ModModModRateCode DetailCode234	Mod Mod Mod Rate
Psychiatric Health Facility Service, Per Diem	H2013	
Unit Value	Per Diem CA-LOCUS Level 6	Level 6
Service Definition	A short-term stay in a licensed and accredited community-based hospital for the treatment or rehabilitation of a psychiatric and/or substance related disorder. Services are of short duration and provide treatment for an acute psychiatric or behavioral episode. For clinically appropriate transitional age youth, this service may also include Medically Managed Inpatient Detoxification at ASAM Level 4-WM.	tance related disorder. Services uth, this service may also include
	For youth defined as the target population for the DBHDD contract, the Inpatient Psychiatric hospital will accept referrals for admission solely from DBHDD and its designated ASO agents: Behavioral Health Link (BHL) or Beacon Health Options (BHO). This service will utilize the DBHDD-required board monitoring system, providing regularly updated information to ensure appropriate utilization of inpatient beds. Admissions are for a:	solely from DBHDD and its oard monitoring system,
Admission Criteria	 Youth with a mental disorder/serious emotional disturbance, who presents a substantial risk or harm to himself/herself or others, as manifested by recent overt acts or recent expressed threats of major suicidal, homicidal or high-risk behaviors as a result of the mental disorder/serious emotional disturbance which present a probability of physical injury to himself/herself or others; OR Youth with a mental disorder/serious emotional disturbance who is so unable to care for his/her own physical health and safety as to create an imminently life- endangering crisis. 	as manifested by recent overt tional disturbance which present s to create an imminently life-
Continuing Stay Criteria	1. Youth continues to meet admission criteria; and 2. Youth's withdrawal signs and symptoms are not sufficiently resolved to the extent that they can be safely managed in less intensive services.	ive services.
Discharge Criteria	 An adequate continuing care plan has been established; and one or more of the following: Youth no longer meets admission and continued stay criteria; or Family requests discharge and youth is not imminently dangerous to self or others; or Transfer to another service/level of care is warranted by change in the individual's condition; or Individual requires services not available in this level of care. 	
Service Exclusions	This service may not be provided simultaneously to any other service in the service array excepting short-term access to services that provide continuity of care or support planning for discharge from this service.	provide continuity of care or
Clinical Exclusions	Youths with any of the following unless there is clearly documented evidence of an acute psychiatric/substance use disorder episode overlaying the diagnosis: Autism, Intellectual/Developmental Disabilities, Neurocognitive Disorder; or Traumatic Brain Injury.	verlaying the diagnosis: Autism,
Required Components	 If providing withdrawal management services, the program must be licensed by DCH/HFR under the Rules and Regulations for Drug Abuse Treatment Programs, 290-4-2 OR is licensed as a hospital/specialty hospital. A physician's order in the individual's record is required to initiate withdrawal management services. Verbal orders or those initiated by a Physician's Assistant or Clinical Nurse Specialist are acceptable provided they are signed by the physician within 24 hours or the next working day. 	orug Abuse Treatment Programs, ed by a Physician's Assistant or

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Community Staffing Requirements Reporting and Billing Requirements	- 1 Onl	Staffing Staffing Staffing Staffing Staffing Staffing An ursing or other licensed medical staff under supervision of a physician may provide withdrawal management services. Requirements 1. This service requires authorization via the ASO via GCAL Providers will select an individual from the State Contract Bed (SCB) Board. Once they accept them, they will assign the individual to a bed on the inventory status board (via bhlweb). Once an individual is assigned to the inventory status board (on belining and an email will be generated and sent to the designated UM of the SCB facility containing the authorization number. Span billing may occur for this service, meaning the start and end date are not the same on a given service claim line. The span dates may cross months (start and end start and end date are not the same on a given service claim line. The span dates are not the same on a given service claim line. The span dates are not the same on a given service claim line. The span dates are not the same on a given service claim line. The span dates are not the same on a given service claim line. The span dates are not the same on a given service claim line. The span dates are not the same on a given service claim line. The span dates are not the same on a given service claim line.
		date and date on a given service line may begin in one month and end in the next).
	~	3. Providers must submit a discharge summary into the provider connect/hatch system within 48 hours of discharge

Coordinate	Coordinated Specialty Care for First Episode Psychosis Program (CSC for FEP) (Effective Date January 1, 2023)	Episode P	sychos	is Pro	gram	CSC for	·FEP) (Effective 🏻	ate Janua	ry 1, 202			
Transaction Code	Code Detail	Code Mod	_	Mod Mod 2 3	Mod 4	Rate	Code Detail	Code	Mod 1	Mod Mod 2 3	Mod 4	Rate
	See	Billing & Rep	orting Re	quireme	ents sec	tion below	See Billing & Reporting Requirements section below for services billing detail.	tail.				
Service Definition	Coordinated Specialty Care for the First Episode Psychosis Program (CSC for FEP) is a team-based, time-limited, multi-faceted approach to treating youth and young adults, ages 16-30, experiencing first episode psychosis. The CSC for FEP model's guiding principles include early detection of psychosis; rapid access to specialty care; flexible, accessible, youth-friendly, and welcoming services; recovery-focused interventions; and respect for young adults striving for autonomy and independence. Component interventions include case management, psychotherapy, supported education and employment services, family education and support, and medication management. CSC for FEP emphasizes shared decision making as a means for addressing the unique needs, preferences, and recovery goals of the individuals served. Collaborative treatment planning in CSC for FEP is a respectful and effective means for establishing a positive therapeutic alliance and maintaining engagement with young people and their family members over time. CSC for FEP services are also highly coordinated with primary medical care, with a focus on optimizing overall mental and physical health. As such, the team is multidisciplinary, includes weekly integrated treatment team meetings, and spans the fields of psychiatry, nursing, counseling/psychology, social work, and career planning; additionally, Certified Peer Specialists on the team provide assistance with the development of natural supports, and promoting socialization and community integration. CSC for FEP team members are expected to maintain knowledge and skills according to the current research trends in best practices and evidence-based treatment, including the provision of trauma-informed, culturally competent care, and the use of effective engagement strategies for youth and young adults. The CSC for FEP model emphasizes flexibility, with services delivered in home, community, and youth-friendly and welcoming office settings depending on the participants' needs and preferences. Services are indivi	First Episode I st episode psy andly, and welcontions include contions include control at their family more family social and promoting social most profession family fa	Psychosis chosis. The oming servase manales shared ag in CSC embers on such, the twork, and ocialization actices an actices an adding on the decipies of the such such such such such such such such	Program e CSC for inces; rec gement, decision for FEP i ver time. Ver time. I career produced eviden adults. The participate of participate is the participate of the participate of the content of the participate of the participate of the content of the participate of the participate of the content of the participate of the content of	(CSC fo or FEP m covery-fo psychott making is a respa CSC for CSC for ultidiscip blanning; mmunity ce-basec he CSC	r FEP) is a odel's guidicalel's guidicalel's guidicaler erapy, supplies a means sofful and e rep service linary, incluadditionally integration. I treatment, for FEP mo eds and pre eds and pre	ychosis Program (CSC for FEP) is a team-based, time-limited, multi-faceted approach to treating youth and ycosis. The CSC for FEP model's guiding principles include early detection of psychosis; rapid access to special ing services; recovery-focused interventions; and respect for young adults striving for autonomy and se management, psychotherapy, supported education and employment services, family education and support shared decision making as a means for addressing the unique needs, preferences, and recovery goals of the shared decision making as a means for addressing the unique needs, preferences, and recovery goals of the in CSC for FEP services are also highly coordinated with primary medical care, with a focus on ch, the team is multidisciplinary, includes weekly integrated treatment team meetings, and spans the fields of ork, and career planning; additionally, Certified Peer Specialists on the team provide assistance with the ialization and community integration. CSC for FEP team members are expected to maintain knowledge and slatices and evidence-based treatment, including the provision of trauma-informed, culturally competent care, and young adults. The CSC for FEP model emphasizes flexibility, with services delivered in home, community, and on the participants' needs and preferences. Services are individually tailored to address participants'	multi-faceted a valential detection of p valential strong adults strong adults strong adults at look and a positive at ed with prima at ment team on the team on the team on the same expectation with services of dividually tailong a valent and a valential at look and a valential and a valential and a valential and valential	approach triving for an riving for a see, family ences, and ences, and the provide as provide as provide as ted to main red to delivered ir red to addrivered ir red to addrivered in the souther and to addrivered in the seek of the see	o treating y apid access utonomy a education I recovery (ic alliance care, with nd spans the sistance w train knowl ally compet on thome, co ess particil	outh and you as to specialt and and support, goals of the and maintair a focus on the fields of the edge and sk ent care, and mmunity, an sants'	y y and and iils d the
	preferences and goals. Based on the needs of the individual, the following services may be provided by qualified CSC for FEP team members and billed under the Non-intensive Outpatient Services Type of Care (see the Service Definition/Requirements for each service listed below in this Provider Manual)*: 2. Diagnostic Assessment; 3. Service Plan Development; 4. Crisis Intervention; 5. Individual Counseling; 6. Group Counseling; 7. Family Counseling/Training;	al, the following rvice Definition/ ent;	services Requirem	may be p ents for e	provided leach serv	by qualified ioe listed b	CSC for FEP team mem slow in this Provider Man	oers and billed 	under the l	Non-intens	ive Outpatie	ŧ

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9	 Community Support (C&A) Peer Support-Individual (Adult MH/AD, C&A Parent/Youth); Psychiatric Treatment; Medication Administration; Nursing Assessment and Health Services; Pharmacy & Lab; Psychological Testing Community Transition Planning 	* In addition to the billable DBHDD services named above, the DBHDD provides ancillary funding through CSC for FEP provider contracts for education and employment support interventions/activities, which are integral to the CSC for FEP model; and for other non-billable activities as described in the paragraph below.	1. Psychoeducation on first episode psychosis, treatment options, and recovery to participants and their families; 2. Crisis planning, support, and intervention; 3. Recovery-based goal setting; 4. Instrumental/skill-building support to participants and their families; 5. Service and resource coordination, including linkage to medical care; 6. Psychotherapy and skills training; 7. Family counseling, education, support, and skills training; 8. Substance use disorder counseling and interventions; 9. Peer support; and	As an adjunct to direct service provision, CSC for FEP teams offer outreach and education activities/events within the community at large in order to identify individuals experiencing a first episode of psychosis, as well as to educate the community about behavioral health conditions, the CSC for FEP program, recovery principles and practice, and accessing the public behavioral health system. Outreach and education efforts are intended to establish a seamless community system of care for youth and young adults with first episode psychosis, and promote the sustainability of the program. The DBHDD provides funding to offset the costs for providers' time spent in these and other non-billable activities such as travel, meetings, trainings and conference attendance, community partner collaboration, and other related activities.	It is anticipated that individuals participating in CSC for FEP will experience a reduction in psychiatric symptoms or the debilitating effects of these symptoms; will show improved educational, and social functioning; and will require less frequent hospitalization and use of crisis services over time. Most participants remain with CSC for FEP programs should be based on clinical considerations. 1. The target population for Coordinated Specialty Care for First Episode Psychosis is youth and young adults aged 16 – 30 with non-organic psychotic disorders with psychotic symptoms (e.g. bipolar disorder with psychotic symptoms; major depressive disorder with psychotic symptoms of psychosis for no longer than 24 months.
C001					Admission

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outh ir	oals identified in the Individualized Recovery Plan (IRP), but goals nave not yet been achieved, and/or new	v-03088-E	most services are excluded, with the exceptions of: provider shall be in close coordination with the Residential/Housing Support provider such that there is no	a substance use disorder is identified and documented as a clinical need unable to be met by the CSC for or organisates that provision of CSC for FEP services alone, without an organized SUD program model, is aim sobriety, CSC for FEP teams may assist the individual in accessing this service, but must ensure clinical as. If CSC for FEP and SAIOP are provided by the same agency, the agency may update the existing that the SAIOP program; unseling/Training provided outside of the CSC for FEP program when the needs of an individual exceed that team. For example, the individual may participate in SA group treatment provided by a Tier 1, Tier 2, or SA-	tment modality (e.g. Individual Counseling, Group eds of an individual exceed that which can be provided rders, and/or other specific clinical specialized ipation in such services along with medical record e coordination towards goals and to prevent any	
Coordinated Specialty Care for First Episode Psychosis Program (CSC for FEP) (Effective Date January 1, 2023) 2. The target population is not to be limited to insurance coverage or lack thereof: individuals who have any kind of third-party insurance, or no insurance, must be served by the provider. 3. Youth and young adults who fall outside the target age range of 16 – 30, or who have had psychotic symptoms longer than 24 months, may be considered for enrollment in CSC for FEP services on a case-by-case basis, with prior approval from DBHDD. 4. An individual does not need to have a diagnosis of a psychotic disorder to be evaluated for enrollment and thus will not have received a diagnosis prior to their evaluation with the CSC for FEP teams, they will have had no previous mental health treatment and thus will not have received a diagnosis prior to their evaluation with the CSC for FEP team.	Individual demonstrates documented progress relative to goals identified in the Individualized Recovery Plan service needs have been identified.	An adequate continuing care plan has been established; and one or more of the following: 1. Goals of the IRP have been substantially met; 2. Individual/family requests discharge and individual is not in imminent danger of harm to self or others; or 3. Transfer to another service is warranted by change in individual's condition and/or needs.	ention and I	duplication of services supports/efforts); b. Substance Abuse Intensive Outpatient Program: If a substance use disorder is identified and documented as a clinical need unable to be met by the CSC for FEP team, and the individual's current treatment progress indicates that provision of CSC for FEP services alone, without an organized SUD program model, is not likely to result in the individual's ability to maintain sobriety, CSC for FEP teams may assist the individual in accessing this service, but must ensure clinical coordination in order to avoid duplication of services. If CSC for FEP and SAIOP are provided by the same agency, the agency may update the existing authorization to include group services to be utilized by the SAIOP program; c. The following are not service exclusions: i. Individual Counseling and Group/Family Counseling/Training provided outside of the CSC for FEP program when the needs of an individual exceed that which can be provided by the CSC for FEP team. For example, the individual may participate in SA group treatment provided by a Tier 1, Tier 2, or SA-		 2. On an individual basis, up to eight (8) weeks of some services may be provided to CSC for FEP participants to facilitate a smooth transition from CSC for FEP to these other community services. A transition plan must be adequately documented in the treatment plan and clinical record. These services are: a. Case Management/Intensive Case Management. b. Psychosocial Rehabilitation-Individual/Program c. AD Support Services d. Behavioral Health Assessment e. Service Plan Development f. Diagnostic Assessment g. Physician Assessment
Coordinate	Continuing Stay Criteria	Discharge Criteria			Service Exclusions	

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Coordinated	Coordinated Specialty Care for First Episode Psychosis Program (CSC for FEP) (Effective Date January 1, 2023)
	i. Peer Support
Clinical 2. Exclusions 3.	Individuals with severe and profound intellectual/developmental disability are excluded because the severity of cognitive impairment precludes participation in services at this level of care. Individuals with mild or moderate intellectual/developmental disability are excluded unless there is an identified mental illness that is the foremost consideration for this psychiatric intervention, and the individual is able to benefit from the cognitive behavioral-based program components. Individuals with medical conditions suspected to be causing the psychotic symptoms are excluded. [Examples: Neurological conditions including traumatic brain injury; brain tumor; endocrine, metabolic, or autoimmune disorders with central nervous system involvement.] Individuals whose psychotic symptoms are suspected to be caused by drug or alcohol intoxication or withdrawal are excluded.
	CSC for FEP must include a comprehensive and integrated set of medical and psychosocial services provided in home, community, and office settings by a multidisciplinary team. The team must provide community-based supportive and recovery-oriented services interwoven with treatment services. Services and interventions must be individually tailored to the needs, goals, preferences, and strengths of the individual need and preference. Services and interventions must be individually tailored to the needs, goals, preferences, and strengths of the individual need and preference. There is no requirement that every CSC for FEP participant works with every member of the team, as interventions should be tailored to the unique needs and preferences of each participant. The CSC for FEP team must maintain a small participant-to-clinician ratio, with an expected census of 30 participants at a point-in-time based on a team FTE of approximately 5.0. The CSC for FEP team must maintain a high percentage of enrolled individuals in services with few dropouts. In the event that the CSC for FEP program documents multiple attempts to locate and make contact with an individual and has demonstrated diligent search, after 90 days of unsuccessful attempts the individual may be discussed due to drop out. The CSC for FEP team must hold weekly team meetings. All CSC for FEP team meetings is to review the clinical status of all individuals in the CSC for FEP program and the outcome of the most recent staff contacts more than the parties to noncess toward their most recent staff contacts individuals in progress toward their most recent staff contacts individuals and the particles to an entire transfer to the purpose of the team meetings is to review the clinical status of all individuals in the descriptions of the proposes toward their most recent staff contacts and extracting the descriptions of the propose of the team meetings is to review the other program and strategies and extracting the program and the outcome of the most recent s
Required 8. Components 9. 11	. -
	Relationships.

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Coordinated Specialty Care for First Episode Psychosis Program (CSC for FEP) (Effective Date January 1, 2023) 12. In addition to services provided to individuals enrolled in the program, the CSC for FEP team must provide outreach and education activities/events to the community at large regarding behavioral health conditions, first episode psychosis and the CSC for FEP program, recovery and wellness principles and practice, and information on how to access the public behavioral health system. 13. CSC for FEP providers must have policies and procedures governing the provision of community outreach and education services, including methods for protecting the safety of staff who engage in these activities.	 1. Coordinated Specialty Care team members must include: a. (1 FT Employee required): One full-time Team Leader who is the clinical and administrative supervisor of the team, and who also functions as a practicing clinician on the team. The Team Leader must be a FT employee and must have one of the following qualifications to be an independently licensed practitioner: i. Physician ii. Physician's Assistant iv. APRN v. RN with a 4-year BSN vi. LCSW vii. LPC 	b. (Variable	 i. Provides clinical and crists services to all team participants; ii. Works with the team to monitor each individual's clinical and medical status and response to treatment; iii. Directs psychopharmacologic and medical treatment for CSC for FEP participants; iv. Participates in the CSC for FEP team meetings weekly. c. (Variable: .15 FTE based on CSC for FEP team census of 30 participants): one Nurse (RN) who: i. Provides nursing services for all participants, including health and assessments, education on treatment adherence, nutrition, exercise, smoking cessation, and other health and wellness-related topics as needed; iii. Works with the team to monitor each individual's overall physical health and wellness, clinical status and response to treatment; and iiii. Participants in the CSC for FEP team meetings weekly. 	 d. If the Team Lead is not a licensed psychologist, LCSW, LPC, LMFT, LMSW, LAPC, or LAMFT, there must be an additional 0.5 FTE team member who holds one of these licensed credentials or associate licensed credentials (note that associate-level clinicians must be under supervision in accordance with O.C.G.A. § 43-10A-11). e. (1 FTE required): One full-time Case Manager who provides concrete needs assistance to CSC for FEP participants and who participates in the CSC for FEP team Lead. f. (1 FTE required): One full-time Education and Employment Specialist who provides support to CSC for FEP participants on their educational and vocational goals, and who participates in the CSC for FEP team meetings weekly. The Education and Employment Specialist or Certified Peer Specialist -Youth who are fully integrated into the team and promote g. (1 FTE required): One or two Certified Peer Specialist or Certified Peer Specialist-Youth who are fully integrated into the team and promote
Coordi		Staffing Requirements		

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Coordinate	Coordinated Specialty Care for First Episode Psychosis Program (CSC for FEP) (Effective Date January 1, 2023)
	individual self-determination and decision-making and provide essential expertise and consultation to the entire team to promote a culture in which each participant's point of view and preferences are recognized, understood, respected and integrated into treatment and community integration activities. CPSs/CPS-Ys participate in the CSC for FEP team meetings weekly and are supervised by the Team Lead. In (Variable: 0.5 FTE based on CSC for FEP team census of 30 participants): One fully licensed or associate-level licensed clinician who specializes in family counseling, or a Certified Peer Specialist-Parent (CPS-P) who provides education, support, and training to family members of CSC for FEP participants. This practitioner bills the Parent Peer Support service (if a CPS-P) or Family Counseling/Training otherwise. The provider is strongly encouraged to utilize the Parent Peer Support service if a CPS-P is available, to meet the recovery needs of the family. This team member participates in the CSC for FEP team meetings weekly and is supervised by the Team Lead.
Clinical Operations	 Individuals receiving CSC for FEP do not med to have a qualifying diagnosis prior to the mitial evaluation for eligibility for CSC for FEP enrollment. As stated above, it is anticipated that many youth and young adults referred to CSC for FEP team. Because CSC for FEP-eligible individuals may be difficult to engage, the initial treatment/ecovery plan for an individual may be more generic at the onset of treatment/support. It is expected that the plan be individualized and recovery-oriented after the individual becomes engaged with the team. Because CSC for FEP-eligible individuals may be difficult to engage, the initial treatment/support. It is expected that the plan be individualized and recovery-oriented after the individual becomes engaged with the team. Because nany individuals served may have co-occurring mental health and substance use disorder recovery. CSC for FEP team sare expected to participate actively and assertively in transitional planning for the individual becomes actively and assertively in transitional planning for the individual and enronstrable plan for timely follow-up on referrals to and from their service, making sure individuals are connected to resources to meet their needs in alignment with their preferences. The team is expected to coordinate care through a demonstrable plan for timely follow-up on referrals to and from their service, making sure individuals has access to services and resources such as housing, pharmacy, benefits, a support network, etc. when being discharged from a psychiatric hospital. CSC for FEP team is required to resources from jail; or experiencing an episode of homelessness. CSC for FEP team is required to respond to the crisis needs of definition for either ADSS, CM, CTP, or CSI, that service should be billed in accordance with the particular scope of service defined within this Manual. The CSC for FEP team is required to respond to the crisis
Service Accessibility	 The CSC for FEP team must respond to phone calls from participants and family members 24-hours/365-days, and either directly provide or refer individuals/families to any appropriate crisis services. Answering devices/Services/Georgia Crisis and Access Line do not meet the expectation; CSC for FEP team staff members must provide this phone coverage. The team must be able to rapidly respond to early signs of relapse and symptom recurrence and must have the capability of providing multiple contacts daily to individuals in acute need. There must be documented evidence that service hours of operation include evening, weekend and holiday hours.
Documentation Requirements	 Each CSC for FEP program must provide monthly fidelity and outcomes data as defined by the DBHDD. The CSC for FEP must have documentation (e.g., notebook, binder, file, etc.) of treatment team meetings to include: a. Date, start time, and end time for the meeting;

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Crisis Stabilization Unit (CSU) Services	lization U	חונ (כא	() ver	vices										
Transaction Code	Code Detail	Code	Mod 1	Code Mod 1 Mod 2	Mod 3	Mod 4	Rate	Code Detail	Code	Mod 1	Mod 1 Mod 2	Mod 3	Mod 4	Rate
Behavioral Health; Short- term Residential (Non-Hospital Residential Treatment Program W/o Rm & Board, Per Diem)		H0018	НА				209.22	Behavioral Health; Short-term Residential (Non-Hospital Residential Treatment Program W/o Rm & Board, Per Diem), Transition Bed	H0018	HA	TB	U2		Per negotiation
Unit Value	1 day							Utilization Criteria	1 unit					
	This is a re provides m services m	sidential a edically m ay include	Ilternative Ionitored r	to or diversidential	services sealth Prov	inpatien for the pu ider Certi	t hospitalization, offerir irpose of providing psy fication and Operation	This is a residential alternative to or diversion from inpatient hospitalization, offering psychiatric stabilization and withdrawal management services. The program provides medically monitored residential services for the purpose of providing psychiatric stabilization and/or withdrawal management on a short-term basis. Specific services may include (see Behavioral Health Provider Certification and Operational Requirements for Certified Crisis Stabilization Units (CSUs), 01-325):	n and with or withdra fied Crisis	drawal m wal mana Stabiliza	anageme Igement c	int service on a short- (CSUs), (s. The pre-term bas 01-325):	ogram is. Specific
	е. х	 a. Psychiatric, diagnostic, and medical assessments; 	diagnostic	, and mec	icai asse	ssments,								

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Brief individual, group and/or family counseling; and

Linkage to other services as needed.

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Medically Monitored Residential Substance Withdrawal Management (at ASAM Level 3.7-WM);

Medication administration, management and monitoring;

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Service Definition Psychiatric/Behavioral Health Treatment;

Nursing Assessment and Care;

Crisis assessment, support and intervention;

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Crisis Stabil	Crisis Stabilization Unit (CSU) Services
Admission Criteria	 Treatment/Services at a lower level of care have been attempted or given serious consideration; and Child/Youth has a known or suspected illness/disorder in keeping with one of the following target populations: A child/Youth who is experiencing a: a. Severe situational crisis; or b. Mental Illness or Severe Emotional Disturbance (SED); or c. Substance Use Disorder; or d. Co-Occurring Substance Use Disorder and Intellectual/Developmental Disability; or f. Co-Occurring Mental Illness and Intellectual/Developmental Disability; and 3. Child/Youth presents a substantial risk of harm or risk to self, others, and/or property or is so unable to care for his or her own physical health and safety as to create a life-endangering crisis. Risk may range from mild to imminent; or a. Child/Youth has insufficient or severely limited resources or skills necessary to cope with the immediate crisis; or b. Child/Youth has insufficient or severely limited resources or skills necessary to cope with the immediate crisis; or c. Child/Youth has insufficient or severely limited resources or skills necessary to cope with the immediate crisis; or d. For withdrawal management services, individual meets diagnostic criteria under the DSM for substance use, exhibiting withdrawal signs, symptoms, behaviors, or functional impairments and can reasonably be expected to respond to withdrawal management treatment.
Continuing Stay Criteria	This service may be utilized at various points in the child's course of treatment and recovery; however, each intervention is intended to be a discrete time-limited service that stabilizes the individual. These time limits for continued stay are based upon the individual's specific needs.
Discharge Criteria	 Child/Youth no longer meets admission guidelines requirements; or Crisis situation is resolved and an adequate continuing care plan has been established; or Child/Youth does not stabilize within the evaluation period and must be transferred to a higher intensity service.
Clinical Exclusions	 Child/Youth is not in crisis. Child/Youth does not present a risk of harm to self or others or is able to care for his/her physical health and safety. Severity of clinical issues precludes provision of services at this level of intensity. See <u>CSU: Medical Evaluation Guidelines and Exclusion Criteria for Admission</u> to Crisis Stabilization Units, 01-350.
Service Exclusions	1. This is a comprehensive service intervention that is not to be provided with any other service(s), except for the Crisis Services Type of Care.
Required Components	 CSUs providing medically monitored short-term residential psychiatric stabilization and/or withdrawal management services shall be designated by DBHDD as both an emergency receiving facility and an evaluation facility and must be surveyed and licensed by the DBHDD. In addition to all service qualifications specified in this document, providers of this service must adhere to Behavioral Health Provider Certification and Operational Requirements for Certified Crisis Stabilization Units (CSUs), 01-325. Youth occupying transitional beds must receive services from outside the CSU (i.e. community-based services) on a daily basis. Services must be provided in a facility designated as an emergency receiving and evaluation facility. A CSU must have documented operating agreements and referral mechanisms for psychiatric disorders, substance use disorders, and physical healthcare needs that are beyond the scope of the CSU and that require inpatient treatment. Operating agreements must specifically address the criteria and procedures for transferring the youth. A CSU must have document facility when the CPS is unable to stabilize the youth. Crisis Stabilization Units (CSU) must continually monitor the bed-board, regardless of current bed availability, and review, accept the individual who is most in need. CSUs are expected to review, accept or decline at least 90% of all individuals placed on a bed-board over the course of a fiscal year.

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Crisis Stabili	Crisis Stabilization Unit (CSU) Services
	8. A physician–to-physician consultation is required for all CSU denials that occur when that CSU has an open/available bed.
	 A physician or a staff member under the supervision of a physician, practicing within the scope of State law, must provide CSU Services. All services provided within the CPS must be delivered under the direction of a physician. A physician must conduct an assessment of new admissions, address issues of care, and write orders as required.
Staffing	 If the charge nurse is an APRN, then he/she may not simultaneously serve as the accessible physician during the same shift. A CSU must have an independently licensed/credentialed practitioner (or a supervised S/T) on staff and available to provide individual, group, and family therapy.
Kequirements	
	8. Functions performed by Physician Assistants, Nurse Practitioners, Clinical Nurse Specialists, Registered Nurses, and Licensed Practical Nurses must be
	performed within the scope of practice allowed by State law and Professional Practice Acts. 9. CSUs are strongly encouraged to employ a CPS (Parent or Youth) as part of their regular staffing compliment, and utilize them in early engagement, orientation to services family support skills huilding IRP development discharge planning and affercare followards
	1. A physician must evaluate a child/youth referred to a CSU within 24 hours of the referral.
	3. The following restraint practices are prohibited:
	a. The use of chemical restraint for any individual. b. The combined use of seclusion and mechanical, and/or manual restraint.
	•
Clinical	d. PRN orders for seclusion or any form of restraint.
Operations	
	g. Use of seclusion or restraint as a part of a Behavior Support Plan (BSP) or an Individual Recovery Plan (IRP).
	h. The use of handcuffs for an individual not under the jurisdiction of the criminal justice system. i. The use of medication as a chemical restraint.
	4. For child/youth with co-occurring diagnoses including Intellectual/Developmental Disabilities, this service must target the symptoms, manifestations, and skills-
	gevelopment related to the identified benavioral nearth issue. 5. Child/Youth served in transitional beds may access an array of community-based services in preparation for their transition out of the CSU and are expected to
Additional Medicaid	 Crisis Stabilization Units with 16 beds or less may bill services to GAMMIS for Medicaid FFS recipients. Medicaid claims for this service may <u>not</u> be billed for any service provided to Medicaid-eligible individuals in CSUs with greater than 16 beds.
Reduirements	
Reporting and	1. This service requires authorization via the ASO via GCAL. Providers will select an individual from the State Contract Bed (SCB) Board. Once they accept them, they will assign the individual to a bed on the inventory status board (via bhlweb). Once an individual is assigned to the inventory status board a tracking number
Billing	will be generated and the information will be sent from the Georgia Collaborative ASC care management. team for registration/authorization to take place. Once an authorization number is assigned, that number will appear on the beds inventory status board (on
Reduirents	
	2. Providers must report information on all midividuals served in Cook no matter the furthing source.

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Crisis Stabil	izat	Crisis Stabilization Unit (CSU) Services
	3.	The CSU shall submit prior authorization requests for all individuals served (state-funded, Medicaid funded, private pay, other third-party payer, etc.);
	4.	The CSU shall submit per diem encounters (H0018HAU2 or H0018HATBU2) for all individuals served (state-funded, Medicaid funded, private pay, other third-
		party payer, etc.);
	5.	Providers must designate either CSU bed use or transitional bed use in encounter submissions through the presence or absence of the TB modifier. TB represents
		"Transitional Bed."
	9	Unlike all other DBHDD residential services, the start date of a CSU span encounter submission may be in one month and the end date may be in the next. The
		span of reporting must cover continuous days of service and the number of units must equal the days in the span.
	7.	Providers must submit a discharge summary into the provider connect/batch system within 72 hours of CSU discharge.
	1.	Individuals receiving services within the CSU shall be reported as a per diem encounter based upon occupancy at 11:59PM. At 11:59PM, each individual reported
		must have a verifiable physician's order for CSU level of care [or order written by delegation of authority to nurse or physician assistant under protocol as specified
a citota con co		in § 43-34-23]. Individuals entering and leaving the CSU on the same day (prior to 11:59PM) will not have a per diem encounter reported.
Doguiromente	2	For individuals transferred to transitional beds, the date of transfer must be documented in a progress note and filed in the individual's chart.
ואפלימוו פווופוווים	რ.	In addition to documentation requirements set forth in Part II of this manual, the notes for the program must have documentation to support the per diem including
		admission/discharge time, shift notes, and specific consumer interactions.
	4.	4. Daily engagement in community-based services must also be documented in progress notes for those occupying transitional beds.

	Rate				
	Mod	4			
	Mod	က			
	Mod	2			
	Mod	-			
(Q	Code				
n Spectrum Disorder (AS	Code Detail				
Autism	Rate				
scent	Mod	4			
doles	Mod	က			
and A	Mod	7			
Shild	Mod	_			
ices – (Code			TBD	
risis Stabilization Unit (CSU) Services – Child	Code Detail			TBD	
Crisis Stak	Transaction	Code	ASD Crisis	Stabilization	Unit

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Crisis Sta	Crisis Stabilization Unit (CSU) Services – Child and Adolescent Autism Spectrum Disorder (ASD)	
	The ASD CSU service is a short-term residential alternative to/diversion from inpatient hospitalization for youth with ASD who present with severe and challenging behaviors that seriously and imminently compromise health, safety, and/or ability to remain in the community. The primary purpose of the ASD-CSU is to provide individualized applied behavior interventions services to decrease the challenging behaviors that place the youth and/or others at serious risk, increase communication	
	skills and adaptive skills to help mitigate the challenging behavior, and increase a caregiver's ability to support the youth in the community. The primary treatment modalities used to achieve these goals are Applied Behavior Analysis and Clinical Behavior Analysis, utilizing trauma-sensitive approaches. Additional supports such as psychiatric stabilization and substance use treatment may be provided as clinically necessary.	Case
Service	Specific services include: A. Crisis-related assessment, including: A diagnostic assessment, functional behavior assessment, adaptive skills assessment, psychiatric assessment, and	1:16-cv
Definition	-	-03088
	C. Medication administration, management, and monitoring; D. Nursing assessment and care, including assistance with ADLs as needed; E. Brief individual, group and/or family counseling as needed and appropriate;	-ELR
	F. Discharge planning and linkage to other services G. Parent/caregiver training H. Treatment for behavioral health-related comorbidities	Docu
	Youth must meet the following criteria in each of the primary categories (I. through IV.) below:	mer
		nt 44
	or educational classification. In addition to ASD, the youth may also have co-occurring behavioral health diagnoses and/or intellectual/developmental disabilities that present challenges requiring intervention/stabilization. Increasing severe and challenging behaviors, and the need for adaptive skills acquisition treatment/training must be significant presenting needs.	8-73
	H. Harm	File
		d 1
Admission	Child/Youth presents a serious and imminent risk of harm to self or others, so as to create a gravely endangering crisis, as evidenced by one or more of the following:	1/29
Criteria	cation or report of significant impulsivity and/or physical aggression angering to self or others;	9/23
	AND/OR 2. There has been at least one episode of severe and highly acute maladaptive behavior. If continued, the behavior would significantly compromise the child's/youth's ability to safely remain in their home/community, and the behavior cannot be managed at a lower level of care.	Page
	III. Crisis Management/Coping	71 of
	Youth must meet either #1 or 2, in addition to #3 below: 1. Youth demonstrates significant deficits in adaptive skills or significant maladaptive behaviors that interfere with ability to manage the immediate crisis; or 2. Youth demonstrates lack of judgement, impulse control and/or cognitive/perceptual abilities to manage the crisis;	627

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		AND 3. Youth displays high acuity maladaptive behaviors which impact their ability to function in significant life domains: family, school, social, or activities of daily living. This impacts child/youth's ability to manage the crisis situation and remain safely in the community or be supported in a lower level of care.
	≥	Distress/Disruption
	, «	The youth's current behavior supports the need for the safety and structure of treatment/support provided at a high level of care, as evidenced by BOTH Items #1
		1. Less restrictive or intensive levels of treatment/support have been tried or considered, and are not appropriate to meet the individual's needs;
		2. Response to treatment and/or formal/informal support has not been sufficient to resolve the crisis.
	> 2	V. Clinical Need/Level of Care
		Needs short-term, involuntary (1013) or voluntary treatment that includes brief crisis intervention and stabilization, as evidenced by one or more of the following: 1. Treatment/services at a lower level of care have been attempted and has not been sufficient to meet the youth's needs at this time,
		OR 2. Treatment/services at a lower level of care have been given serious consideration and deemed not clinically appropriate to meet the youth's needs at this time.
	-	Individual continues to meet admission criteria as defined above; and
Continuing	2.	A behavior support plan related to the maladaptive behavior has been created/updated and implemented, but the behavior has not stabilized to the extent that the
Stay Criteria		youth can safely return to his or her home/community, and
	ი.	A higher level of care is not indicated.
	~.	Youth no longer meets admission criteria and an adequate discharge/continuing support/care plan has been established; and Youth has achieved behavior goals directly related to the crisis (or behaviors directly related to the crisis have returned to baseline), such that the youth can be
-		safely supported at either a lower level of care or in their natural home/setting.
Discharge Criteria	რ	Youth's legal guardian requests discharge; or
	4.	Youth's behaviors and/or psychiatric symptoms have not stabilized within the crisis stabilization period, and youth must be transferred to a service offering a longer
	ις	duration of intensive treatment/higher level of care; or Youth no longer displays bighty acute maladantive behaviors, however, significant maladantive behaviors are still present and vouth requires additional oppoind
	;	behavior intervention and skill acquisition treatment/training prior to being able to safely be supported in the community.
	←.	All other Medicaid Community Based Rehabilitation Services and DBHDD State Funded Behavioral Health Core and Specialty services are excluded until the individual has been unconditionally discharged from the CSU (with the exception of the Community Transition Planning service for youth with a co-occurring
Service Exclusions	0	noite
	i	
Olinical Exclusions	–: ८: ਲ਼	Children/youth with a behavioral health diagnosis or I/DD diagnosis in the absence of an ASD diagnosis. Children/youth requining substance use withdrawal management. While many facilities use the following as clinical exclusions, the items below are not exclusionary criteria for this service:
		a. Medical Needs:

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Crisis Stabilization Unit (CSU) Services – Child and Adolescent Autism Spectrum Disorder (ASD)

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Crisis Stak	billiz	Crisis Stabilization Unit (CSU) Services – Child and Adolescent Autism Spectrum Disorder (ASD)
		I. ADLs: Inability to independently perform ADLs, as defined below, is <u>not</u> an exclusion criterion for this service. A youth's dependence is defined as
		stall supervision, direction plonible, and personal assistance. 1. Transferring: The extent of a youth's ability to move from one position to another.
		3. Dressing: The ability to select appropriate clothes and put clothes on.
		6. Toileting: The ability to get to and from the toilet, use it appropriately, and clean oneself.
		b. Sexual Risk: Presence of sexually inappropriate behavior is not an exclusionary criterion for this service.
		c. Elopement Risk: Elopement behavior is not an exclusionary criterion for this service. May have recent or historical episodes of elopement behaviors that
		have placed the individual at imminent risk to self or others.
	-	CSUs providing medically monitored short-term residential psychiatric/behavioral stabilization services shall be designated by the Department as both an
	(emergency receiving facility and an evaluation facility and must be surveyed and certified by the DBHDD.
		In addition to all service qualifications specified in this document, providers of this service must adhere to the DBHDD policy <u>Behavioral Health Provider</u> Confidention and Charational Documents for Confidence Charlination Units (CCID) 14, 325, and to all other CCID policies expent as expeditionally denoted for
		this service in policy CSH. Child & Adolescent Autism Spectrum Disorder 01-353
	რ.	Services must be provided in a facility designated as an emergency receiving and evaluation facility.
	4.	A CSU must have documented operating agreements and referral mechanisms for Autism Spectrum Disorder, psychiatric disorders, addictive disorders, and
Components		physical healthcare needs that are beyond the scope of the CSU and that require inpatient treatment. Operating agreements must delineate the type and level of
		service to be provided by the private or public inpatient hospital or treatment facility. These agreements must specifically address the criteria and procedures for
		transferring the youth to a designated treatment facility when the CSU is unable to stabilize the youth.
	5.	Crisis Stabilization Units (CSU) must continually monitor the bed-board, regardless of current bed availability, and review, accept or decline individuals who are
		awaiinig disposition on a bed-board, and provide a disposition based on cirrical review. It is the expectation that this GOO accepts maiyiddais who meet the cirrena shows and who are most in pead
	U	Cailoob 10 too
		coos ale expecieu to leview, accept of decime at least 30 % of all motividuals placed of a bea-board over the course of a fiscal year. A physician—to-physician consult is required for all CSH denials that occur when that CSH has an onen/available had
	<u> </u>	ASD CSU services must be provided by a physician or a physician extender under the supervision of a physician, practicing within the scope of State law. All
		services provided within the CSU must be delivered under the direction of a physician. A physician must conduct an assessment of new admissions, address
		issues of care, and write orders as required.
	2	ASD CSU must employ a full-time (FT) Nursing Administrator who is a Registered Nurse.
	ഗ.	ASD CSU must always have a Registered Nurse present at the facility and maintain the ratio of 1 nurse to 8 individuals served. A second nurse may be a Licensed
į		Practicing Nurse (LPN).
Staffing	4. r	If the Charge nurse is an APRN, then he/she may not simultaneously serve as the accessible physician during the same shift. ASD CSH minst employ a full-time-emilyalent (ETE) Board Certified Rehavior Analysis (ARA)
	5	aspects of treatment.
	9	ASD CSU must employ at least one additional full-time-equivalent (FTE) Board-Certified Behavior Analyst (BCBA) or a Board-Certified Assistant Behavior Analyst
		(BCaBA), who provides oversight to direct care staff during awake hours (first and second shift, 7 days a week). Functions performed by the BCBA or BCaBA must
		be performed within the scope of their practice and aligned with their professional standards. A BCaBA must be supervised by the lead BCBA on staff.
		Staff-to individual served ratios must be established based on the needs of individuals served and in accordance with rules and regulations. A minimum of one (1)
		staff member per four (4) individuals served must always be maintained. Direct care staff may consist of a combination of Registered Behavior Lechnicians (RBT),

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Crisis Stabilization Unit (CSU) Services – Child and Adolescent Autism Spectrum Disorder (ASD)

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Crisis Stabilization Unit (CSU) Services – Child and Adolescent Autism Spectrum Disorder (ASD

- occurring diagnoses. For youth with co-occurring diagnoses, this service must target the symptoms, maladaptive behaviors, and adaptive behavior deficits As part of the needs assessment, provider must work to identify necessary behavioral health and/or I/DD treatments and supports for individuals with corelated to the co-occurring diagnosis and that are relevant to the crisis event.
- implementation, fidelity and progress monitoring will be informed by quantitative data collected on the youth's behaviors while admitted to the ASD CSU. Positive Behavior Support Plans and behavior-change programs will be conceptually consistent with behavior analytic principles. Treatment ö
 - Immediately upon admission, the provider must implement its internal policies and procedures for managing crisis situations, based upon the youth's presenting behaviors and needs.

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- Within 36 hours of admission, an individualized crisis plan must be developed (or updated if one already exists) and implemented for each youth served.
- Within three (3) days of admission, a provisional Positive Behavior Support Plan must be developed (which is primarily focused on the crisis-related behavior) and implemented.
- Within five (5) days of admission, a finalized Positive Behavior Support Plan must be fully implemented. ٦.

Additional Treatment ပ်

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- comorbidities. Therefore, the Contractor shall have adequate treatment options, and referral agreements to treat various types of comorbidities, in Treatment for Comorbidities - Some youth may come to the ASD CSU with psychiatric, intellectual/developmental, substance use, and/or medical accordance with DBHDD CSU policy. All treatment shall be administered by appropriately licensed providers. ä
- licensed clinician with experience and competence in trauma focused behavior therapy to provide therapeutic support to these youth. The ASD CSU shall educate and work with the guardian/caregiver, who should be engaged in the program with the youth, to ensure that youth with trauma are discharged to Treatment of Patients with Trauma- Some youth with ASD and related disorders are more prone to experiencing trauma. The ASD CSU shall provide a safe environments. Ь.
- In addition to providing trauma-specific treatment interventions to children/youth for whom these are needed, the CSU will utilize trauma sensitive approaches in all aspects of support to children, youth, and families.
- Education The ASD CSU will manage the educational needs of the youth in accordance with Georgia law while the youth receives treatment at the ASD CSU. ထဲ တဲ
 - Daily Schedule No more than 30% of all youth's waking hours (except educational schooling, mealtimes and ADL times) should be spent in milieu activities.
- Transitioning Youth from the ASD CSU The ASD CSU will dedicate a staff member whose primary role is to plan the appropriate discharge of the youth from the ASD CSU. This staff will work with the ASD Case Expeditors and other identified and/or established service providers to, at a minimum, complete the following:
 - services and supports. The CSU's case manager must assist each youth and caregiver/family with identifying and accessing needed services/supports Upon admission, provider must begin developing an individualized discharge/transition plan, to include coordination and continuity of post-discharge post-discharge and must update/coordinate with any existing supporting providers and key stakeholders.
 - Research the available community resources and outpatient providers that meet the youth's and caregiver's/guardian's needs, including financial resources and preferences for location; Ю.
- Discuss the transition options with the guardian/caregiver and youth engaging in the process, as appropriate;
- Develop a transition plan, clearly outlining the recommended, continued treatment plan and responsibilities of the guardian/caregiver; Ö.
 - Perform all tasks related to placing the youth with the outpatient providers; ب نه
- At least one (1) follow-up call within seven (7) days of discharge to ensure needed community support connections have been made, and that the discharge plan is being implemented.

Caregiver Training Έ.

- To increase the efficacy of treatment at the unit, the staff of the ASD CSU will provide training for the youth's caregivers, paid and unpaid.
- The ASD CSU will make accommodations to ensure that caregivers are able to participate in training regardless of their proximity in relation to the ASD
- This training shall, at a minimum, result in the following:

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 a. Operational Definition of behaviors b. Description of situations in which the challenging behavior typically occurs c. Common warning signs and/or precursor behaviors that indicate a crisis is imminent d. Identification of staffing needed to carry out crisis curriculum procedures e. Identification of equipment necessary f. Contact immunation of equipment necessary f. Protocols to access community-based crisis services to include the Georgia Crisis Response System, access emergency room care or law enforcement, if the acute crisis presents a substantial risk of imminent harm to self and others must be included in the crisis intervention plan provided upon discharge i. Procedures for debriefing and documentation- A functionally appropriate debriefing should occur. 6. The CSU must have detailed documentation of the interventions that were identified in the Positive Behavior change programs, replacement behaviors, skill exhausted before initiating crisis intervention and the emanating crisis behavior. 7. The ASD CSU must maintain documentation of fidelity monitoring regarding implementation of the Positive Behavior Support Plan and interventions. 8. The ASD CSU must maintain documentation of behavior support plan and intervention competency training of staff and caregivers. 9. The ASD CSU must maintain accumentation of pehavior support plan and intervention competency training of staff and caregivers. 	1. This service requires authorization via the Georgia Collaborative ASO (ASO) via the Georgia Crisis and Access Line. Providers will select an individual from the Referral Board. If they accept an individual, they will assign the individual to a bed on the inventory status board (via bhlweb). Once an individual is assigned to the inventory status board a tracking number will be generated and the information will be sent from the ASO crisis access team to the ASO care management team for registration/authorization to take place. Once an authorization number is assigned, that number will appear on and an email will be generated and sent to the designated UM of the SCB facility containing the authorization number; 2. The CSU must report information on all individuals served (state-funded, Medicaid funded, private pay, other third party payer, etc.); 3. The CSU shall submit per diem encounters (H0018HATBU2) or H0018HATBU2) for all individuals served (state-funded, Medicaid funded, private pay, other third party payer, etc.); 4. The CSU shall submit per diem encounters (H0018HAU2 or H0018HATBU2) for all individuals served (state-funded, medicaid funded, private pay, other third party payer, etc.); 5. Unlike all other DBHDD residential services, the start date of a CSU span encounter submission may be in one month and the end date may be in the next. The span of reporting must cover continuous days of service and the number of units must equal the days in the span; 6. Providers must submit a discharge summary into the provider connect/batch system within 48 hours of CSU discharge.	None ants
	Billing & Reporting Requirements	Additional Medicaid Requirements

Crisis Stabilization Unit (CSU) Services – Child and Adolescent Autism Spectrum Disorder (ASD)

High Utilizer Managemen	Management													
Transaction	Code Detail	Code	Mod	Mod	Mod	Mod	Rate	Code Detail	Code	Mod	Mod	Mod	Mod	Rate
Code			_	7	က	4				_	7	က	4	
High Utilizer Management		T1016	HA	MH										

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approach, HUM service developmental, and oth engagement and time-lifor the programs are to: a. Determine the cultural factors b. Use case man b. Use case man c. Utilize a perso d. Reduce the ince e. Act as a navige e.	approach, HUM services offer care coordination in identifying and gaining access to required services and supports, as well as medical, social, educational, developmental, and other services and supports, regardless of the funding source for the services to which access is sought. The HUM program includes assertive engagement and time-limited follow up to individuals to support and encourage a consistent and ongoing connection with appropriate community resources. Objectives for the programs are to:	С
က် ပေပပာတ်		ase 1:16-c
	Determine the factors related to an individual's high utilization of crisis services (e.g., homelessness, inadequate discharge planning, engagement cultural factors, etc.). Use case management to educate, connect to services, and advocate for the individual. Utilize a person-centered approach to tailor supports to meet the unique needs of the individual served. Reduce the individual's re-admission rate into inpatient settings. Act as a navigator for an individual who has not been able to engage successfully in services beyond a crisis.	cv-03088-ELR
	Reduce the number of people with elevated acute behavioral needs to improve access to care. Elevate identified gaps in resources to regional community collaboratives in order to address these gaps and develop solutions with community partners.	Do
This service 1. Individu 2. Comple 3. Comple 4. Authority 5. Comple 6. Individu	This service supports effective engagement as defined by one or more of the following outcomes: 1. Individual's linkage to the appropriate service(s) and support(s); 2. Completion of an initial evaluation/behavioral health assessment; 3. Completion of a psychiatric evaluation; 4. Authorization for services; 5. Completion of two (2) face-to-face follow up appointments; and/or 6. Individual reports feeling sufficiently supported and connected to desired services.	cument 448-73
Individuals v Community, 1. A 30-da 2. Two (2)	Individuals with a primary substance use, mental health, or co-occurring diagnosis who have been admitted to a crisis setting (CSU, BHCC, State contracted Community-Based Inpatient Psychiatric facility, or PRTF) meeting one of the following frequency rates: 1. A 30-day readmission; or 2. Two (2) admissions within a 12-month period;	Filed 11/2
Admission Criteria 3. Other c a. Th b. Fo c. Tw d. 30	AND/OR Other crisis utilization indicators, as evidenced by the following: a. Three (3) mobile crisis dispatches within 90 days or; b. Four (4) or more mobile crisis dispatches within nine (9) months; or c. Two (2) or more presentations at an Emergency Department within 90-days; and/or d. 30 consecutive days or more in a CSU or State contracted Community-Based Inpatient Psychiatric bed.	29/23 Page
Continuing Stay Individu Criteria	Individual remains disconnected from behavioral health community-based services and supports.	78 of 62

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gh Utilizer	High Utilizer Management	
Discharge Criteria	 Individual has solidified recovery support networks to assist in maintenance of recovery; and Individual reports feeling sufficiently supported and connected to an appropriate level of services and supports. Documented multiple attempts (e.g., a minimum of four attempts over the first two weeks, a minimum of six attempts over the first month, and/or a minimum of eight attempts over a two-month period) to locate and make contact with an individual. The individual may be removed from the caseload due to drop out/unsuccessful engagement after 90-days. 	Cas
Service Exclusions	 This service may not duplicate any discharge planning efforts which are part of the expectation for hospitals, BHCCs, CSUs, and PRTFs. The HUM program is not available to any individual who has an authorization for and is actively engaged in services (as evidenced by face-to- face contact within the past 30-days) with IC3, CME, or IFI. 	se 1:16
Clinical	1. Individuals with the following conditions are excluded from admission unless there is clearly documented evidence of a psychiatric condition co-occurring with the diagnosis of: a. Intellectual/Developmental Disabilities; and/or b. Autism; and/or c. Neurocognitive Disorder; and/or d. Traumatic Brain Injury.	6-cv-03088-ELR
Required		Document 448-73 Filed 11/29/23 Page 79 of 627

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High Utilizer Management Yellow – mid authorized for	lanagement Yellow – mid level – moderate barriers. Individual may or may not have been authorized and/or engaged previously with provider, but is currently neither authorized for services nor connected, individual may have had inadequate/inappropriate level of care; individual may have refused services. Circumstances may
	Red – highest level – severe barriers. No current or previous authorization; individual may be homeless or have other unsafe/unstable housing, may present with medical complexity and/or co-occurring I/DD, involvement with criminal justice system or DFCS; individual may have inappropriate level of care; may have refused services.
2. 1.	
က်	The followi
Staffing Requirements	 Practitioner Level 4: LMSW; LAPC; LAMFT; Psychologist/LCSW/LPC/LMFT's supervisee/trainee with at least a Bachelor's degree in one of the helping professions such as social work, community counseling, counseling, psychology, or criminology, functioning within the scope of the practice acts of the state: MAC, CAADC, CAC-II, GCADC, III, CPS, PP, CPRP or Addiction Counselor Trained/Counselor in Training with at least a Bachelor's degree in
	one of the helping professions such as social work, community counseling, psychology, or criminology • Practitioner Level 5: CPS; PP; CPRP; or, when an individual served has a co-occurring mental illness and substance use disorder: CAC-I, GCADC-I, or Addiction Counselor Trainee/Counselor in Training with high school diploma/equivalent under supervision of one of the licensed/credentialed
4	Staff-to-co rolling cens those who
2. 7	. It is <u>not</u> expected that HUM Navigators participate in or deliver clinical services HUM Navigator service delivery may include (with appropriate consent) coordination with family and significant others and with other systems/supports (e.g., work, school religious entities law enforcement aging agencies etc.) when appropriate for services and supports
S	
4.	locations. HUM Navigators must incorporate assertive engagement techniques to identify, locate, engage, and retain the most difficult to engage individuals who have a history of exclination and out of intensive services.
5.	
Operations 6.	_
	 have had face-to-face contact with individual collaborate to identify most urgent needs
	 collaborate to identify barriers to access treatment/supports, prioritize services
	 report on progress Within 60 days (Focused Resource Engagement)
	 connection to appropriate resources, services (as evidenced by attendance to appointments) convening appropriate parties, treatment providers, natural supports, stakeholders to identify and resolve barriers

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High Utilizer	High Utilizer Management	
	 Within 90 days (Active Monitoring Engagement) Integration into appropriate level of services, supports and other resources. Monitor access and continued engagement in identified services/supports. Transition out of HUM program 	Cas
	 HUM Navigators must: 1. Use case management strategies to educate and connect to services and advocate for individuals. 2. Utilize a person-centered approach to meet the needs of each unique person. 3. Engage individuals who have not been successfully engaged into services beyond a crisis. 4. Use conventional and unconventional methods of engagement to determine barriers to ongoing community-based care. 5. Use a standardized comprehensive needs assessment tool. 	se 1:16-cv-0308
	The HUM program must: 1. Use available data to identify and assign a level of priority (see Required Components) to eligible individuals; 2. Utilize methods, materials, settings, and outside resources appropriate to the developmental and cognitive levels, capabilities, age, gender, and culture of	8-ELR
	participants; 3. Utilize methods, materials, approaches, activities, settings and outside resources appropriate for, and targeted to individuals with Substance Use Disorders and	Doc
	4. Elevate identified gaps in resources to the regional community collaboratives/local interagency planning team chairs to address and develop solutions with	ume
	5. Reduce the number of people with elevated acute BH needs to improve access to care;	nt 4
	 Increase utilization and participation in programming that promotes stability, wellness and recovery; and/or Reduce the re-admission rates of individuals being re-admitted into BHCC, CSU, Private Hospital, PRTF levels of care. 	48-7
	1. There must be documented evidence that service hours of operation are flexible and include outreach and engagement during evenings and weekends. 2. Demographic information collected shall include a preliminary determination of hearing-impairment status to determine the appropriateness of a referral to	'3
Service		File
Accessibility	 HUM Navigators are expected to assertively engage with individuals in settings to include: Hospitals, BHCCs, CSUs, PRTFs, and other community settings. Parents/families/legal guardians are considered to be necessary supports for youth served in the HUM service. However, if the individual served is 18 years 	ed 13
	of age or older, they may choose not to have parents/families engaged.	L/2
	30/60/90-day reporting of progress Date of admission and discharae from HUM program	9/2
	Discharge Disposition:	3
	• Still receiving services;	Р
Documentation	Contipleted receiving services, Refused services:	age
Requirements	Left catchment area;	81
	• Incarcerated; or	LO
	• Other dispositions.	f 62
	Date of this and last morn havigator contact This is identifier for each individual which will follow them across multiple encacements	27
	ID of HUM Provider (T1, T2+), perhaps Federal ID #?	

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	Case 1:16-cv-03088-ELR	Document 44	48-73	Filed 11/29/23	Page	82 of 62
			in the HUM		Mod Rate	employment, both hd work toward
			uals served i		Mod N	maintaining d integrates nctioning, a
			s for individu		Mod Mod	taining and , etc.). SEE heir daily fu
			ad outcomes		Code 1	D/SMI in ob rade school to improve t
	M list? apply):	/ice.	Compliance with monthly programmatic reporting as required by the Department's HUM Coordinator. Each HUM navigator must submit per unit encounters for all individuals served. Post 90-Day Review - The HUM Navigator will provide a monthly programmatic report to DBHDD of the caseload outcomes for individuals served in the HUM program.		Code Detail	e Integrated Supported Employment and Education (SEEd) program supports youth and emerging adults with SED/SMI in obtaining and maintaining employment, alor enrolling in, attending, and completing an education program (high school/GED, higher education, technical/trade school, etc.). SEEd integrates both ployment and educational needs within a single program, and offers supports that enable youth/emerging adults to improve their daily functioning, and work toward
civilig services)) I them on the HU	IM Navigator/sen	by the Departme ndividuals served thly programmati	ogram	Mod Rate	gram supports yo n (high school/G iffers supports the
	llow, Green)	vices services services by the HU	as required ers for all ir vide a mont	SEEd) Pr	Wod 3	SEEd) prograntion program and o
	M (Red, Yes - What facs)	e of OP ser ommunity access state a community	c reporting a init encount ator will pro	cation (§	Mod Mod	Education (g an educa single proc
iddal illiferida (oming into HU Crisis contact contracted bed: jagement in co	anding of valu f services in cc tge in how to a experience with	r programmatic st submit per u te HUM Naviga	t and Educ	Code Mc	ployment and and completin needs within a
Theory Direct Manager Colors	 Urbail Vs. Rufal (based on county) Initial priority level coming into HUM (Red, Yellow, Green) Number and type of Crisis contacts - What factors placed them on the HUM list? ER IP Stay (State contracted beds) BHCC/CSU PRTF Mobile Crisis Initial Barriers to engagement in community treatment (select as many as apply): Homelessness Transportation Inadequate DC planning Cultural factors 	 Lack of understanding of value of OP services Unavailability of services in community Lack of knowledge in how to access state services Prior negative experience with community services Other List of barriers that were successfully removed by the HUM Navigator/service. 	Compliance with monthly programmatic reporting as required by the Department's HUM Coordinator. Each HUM navigator must submit per unit encounters for all individuals served. Post 90-Day Review - The HUM Navigator will provide a monthly programmatic report to DBHDD of t program.	ne. ported Employment and Education (SEEd) Program	de Detail	Integrated Supported Employment and Education (SEEd door enrolling in, attending, and completing an education ployment and educational needs within a single program,

Requirements Reporting

-, <, ∞,

Billing &

None.

Additional

Medicaid

County (where individual intends to reside while receiving services)

High Utilizer Management

Region

Integrated S	Integrated Supported Employment and Education (SEEd) Program	nt and E	ducati	on (S	EEd) P	rogra	٤							
Transaction	Code Detail	Code	Mod	Mod	Mod Mod Mod Rate	Mod		Code Detail	Code	Mod	Code Mod Mod Mod Mod Rate	Mod	Mod	Rate
Code			1	2	3	4				1	2	3	4	
TBD	TBD	TBD												
	The Integrated Supported E	mployment s	and Educ	ation (S	EEd) pro	ogram su	ipports you	The Integrated Supported Employment and Education (SEEd) program supports youth and emerging adults with SED/SMI in obtaining and maintaining employment,	ED/SMI ii	n obtaini	ing and m	naintainin	g emplo	yment,
Service	and/or enrolling in, attending), and compl	eting an	educatic	on progra	ugiu) me	school/GE	and/or enrolling in, attending, and completing an education program (nign scnool/GED, nigner education, tecnnical/trade scnool, etc.). SEEd integrates both	/trade scr	Jool, etc.	.). SEEGI	ıntegrates	s potn	
Definition	employment and educationa	Il needs with	in a sing	le progra	am, and	offers su	pports tha	employment and educational needs within a single program, and offers supports that enable youth/emerging adults to improve their daily functioning, and work toward	s to impro	ve their	daily func	ctioning, a	and worl	k toward
	achievement of their recover	ry and emplc	yment/e	ducation	βoals. ξ	Support i	s available	achievement of their recovery and employment/education goals. Support is available according to individualized goals and needs in the areas of care coordination,	oals and n	eeds in	the areas	s of care	coordina	ation,

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Integrated S	Integrated Supported Employment and Education (SEEd) Program
	assistance with the job and/or school application process, job and/or educational learning skill development, follow-along/on-site mentoring and assistance, and career counseling.
	Enrollment in the SEEd program is based on individual choice. The program utilizes a rapid engagement process to assist individuals with identifying career and/or educational goals, and once identified, with determining the steps required to pursue those goals. As soon as the individual has made some preliminary choices concerning their preferences for a job/career and/or for an educational program/setting, the SEEd program utilizes a rapid application and placement process to help the individual begin the job and/or educational program of their choosing.
Admission Criteria	All interested individuals have access to services regardless of educational/employment readiness factors, symptoms, and history of substance use, violent behavior, cognition impairments, treatment adherence, or personal presentation.
Continuing Stay Criteria	TBD
Discharge Criteria	TBD
Service Exclusions	None
Clinical Exclusions	None
Required Components	 Services begin soon after the person expresses interest. Services begin soon after the person expresses interest. Supported deducation Component – For individuals who want education of career and education activities occur within 30 days of enrollment in the program. Meaningful employment activities could include an exploration of career and educational interests, a tour of a campus, applying for financial aid, or meeting a department leader (among others). Supported Employment Component – For individuals who want employment support, the first meaningful employment activities occur within 30 days of enrollment into the program. Meaningful employment activities could include exploration of career interests, resume/job skill development, or identifying and applying for potential job opportunities (among others). SEEd services are integrated with other services, such as any behavioral health treatment/support that individuals may be receiving. Mhen these other services are rendered by a DBHDD behavioral health or I/DD provider, Supported Education Specialists and Supported Employment Specialists and Supported Employment and Supported Education and Employment Specialists and Supported Employment behavioral health provider. Supported Education and Employment and Supported Education and Employment and Supported Education and Supported Employment Specialists is to assist the individual supers. Supported Employment and Supported Education and Supported Employment Specialists is to assist the individual set of Supported Education and Supported Employment Specialists is to assist the individual set of Supported Education and supported Employment goals. The level of Supported Education and supports are available as a long as the individual set of support is geared to the individual's endine Employment goals. The level of support is geared to the individual's set of individual's educational employment goals of the services are streng

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	Integrated §	Integrated Supported Employment and Education (SEEd) Program
rnts ry ation rnts	Staffing	1. All program staff must be trained in an integrated model including both Supported Education and Supported Employment services.
y ation ints	Requirements	
ty attion onts	Clinical	1. There is a maximum staff to individuals served ratio of 1:25, with the target ratio being 1:20.
ty ation ints	Operations	
ty ation ints	Service	TBD
ation ints	Accessibility	
nts nts	Documentation	Provider will participate in all evaluation, quality improvement, training and fidelity monitoring activities and any other mechanism DBHDD chooses to utilize.
nts	Requirements	
Reporting Beguirements	Billing &	TBD
Beauriements	Reporting	
	Requirements	

Intensive Cu	Intensive Customized Care Coordination						
Transaction Code	Code Detail	Code	Mod 1	Mod 2	Mod 3	Mod 4	Rate
Community- based wrap- around services, monthly	Community-based wrap-around services	H2022	并				
Unit Value	1 month	Maximum Daily Units					
Initial Authorization	3 units	Re-Authorization		90 days			
Authorization Period	90 days	Utilization Criteria		See Admission Criteria below	sion Criteria	n below	
Service Definition	Intensive Customized Care Coordination is a provider-based High Fidelity Wraparound intervention, as defined by the National Wraparound Initiative, comprised of a team selected by the family/caregiver in which the family and team identify the goals and the appropriate strategies to reach the goals. Intensive Customized Care Coordination assists individuals in identifying and gaining access to required services and supports, as well as medical, social, educational, developmental and other services and supports, regardless of the funding source for the services to which access is sought. Intensive Customized Care Coordination encourages the use of community resources through referral to appropriate traditional and non-traditional providers, paid, unpaid and natural supports. Intensive Customized Care Coordination is a set of interrelated activities for identifying, planning, budgeting, documenting, coordinating, securing, and reviewing the delivery and outcome of appropriate services for individuals through a wraparound approach. Care Coordinators (CC), who deliver this intervention, work in partnership with the individual and their family/caregivers/legal guardian are responsible for assembling the Child and Family Team (CFT), including both professionals and non-professionals who provide individualized supports and whose combined expertise and involvement ensures plans are individualized and person-centered, build upon strengths and capabilities and address individual health and safety issues.	ound intervention, as definals and the appropriate straces and supports, as well access is sought. Intensive providers, paid, unpaid ar ocumenting, coordinating, nators (CC), who deliver the I Family Team (CFT), includens are individualized an	ned by the Na ategies to rea as medical, so Customized nd natural sup securing, and intervention is intervention ad person-cention	tional Wraps ch the goals ocial, educa Care Coord oports. Inten ports. Inten d reviewing d reviewing n'essionals & ressionals &	around Init Intensive Intensive Ination end Ination end Ine deliver Ine deliver Intenship in arthership in arther	ative, completed by Constant and Control of	ised of a Care nd other use of ne of idual and who provide
	 Intensive Customized Care Coordination is differentiated from traditional case management by: Coaching and skill building of the individual and parent/caregiver to empower their self-activation and self-management of their personal resiliency, recovery and wellness towards stability and independence. The intensity of the coordination: an average of three hours of coordination weekly. 	nagement by: ower their self-activation a ion weekly.	and self-mana	gement of t	heir persol	nal resiliency	, recovery

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• • •	The frequency of the coordination: an average of one face-to-face meeting weekly. The caseload: an average of ten youth per care coordinator. The average service duration: 12 – 18 months.	
• •	In a average service duration. 12 = 10 months. In the little of the Wrap Team (this CPS-P) as a part of the Wrap Team (this CPS-P, while a required partner in the ICCC process, is billed separately as Parent Peer Support in accordance with this manual.	Cas
• •	Development of a Child and Family Team, minimally comprised of the individual, parent/caregiver, and Wrap Team (CC, CPS-P, and one natural support). A Child and Family Team Meeting (CFTM), held minimally every 30 days, where all decisions regarding the Individual Recovery Plan are made.	se 1:16
Intensiv •	 Comprehensive Customized Care Coordination includes the following components as frequently as necessary: Comprehensive youth-guided and family-directed assessment and periodic reassessment of the individual to determine service needs, including activities such as: that focus on needs identification to determine the need for any medical, educational, developmental or other services and include activities such as: taking individual history; identifying the needs, strengths, preferences and physical and social environment of the individual, and completing related documentation; gathering information from other sources, such as family members, medical providers, social workers, and educators, if necessary, to form a complete assessment of the individual. 	6-cv-03088-EL
•	Development and periodic revision of an individualized recovery plan (IRP), based on the assessment, that specifies the goals of providing care management and the actions to address the medical, social, educational, developmental and other services needed by the individual, including activities that ensure active participation by the individual and others. The IRP will include transition goals and plans. If an individual declines services identified in the IRP, it must be documented.	R Doci
•	Referral and related activities to help the individual obtain needed services/supports, including activities that help link the eligible individual with medical, social, educational, developmental providers, and other programs or services that are capable of providing services to address identified needs and achieve noals in the IRP	ument -
•		448-73
	may be with the individual, family members, providers, or other entities, and may be conducted as frequently as necessary to help determine: whether services/supports are being furnished in accordance with the individual's IRP; whether the services in the IRP are adequate to meet the needs of the individual; whether there are changes in the needs or status of the individual. If changes have occurred, the individual IRP and service arrangements with providers will be updated to reflect changes.	Filed 11/
•	Intensive Customized Care Coordination may include contacts and coordination with individuals that are directly related to the identification of the individual's needs and care, for the purposes of assisting individuals' access to services, identifying needs and supports to assist the individual in obtaining services, providing Care Coordinators with useful feedback, and alerting Care Coordinators to changes in the individual's needs. Examples of these individuals include, but are not limited to, school personnel, child welfare representatives, juvenile justice staff, primary care physicians, etc.	29/23 I
• •		Page 8
Youth (Youth (through age 20) who, based on CANS-Georgia scoring, have:	5 of
4	At least 1 rating of "2" or "3" on the following Child Behavioral/Emotional Needs: • Psychosis • Attention/Concentration	627
r Provi	er Provider Manual for Community Behavioral Health Providers (January 1, 2023)	

Intensive Customized Care Coordination

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Admission Criteria

Intensive Customized Care Coordination - Another - Depension - Authorized Abuse - Shadd Albuse - Shadd Albuse - Physical Abuse - Phy		Case 1:	16-cv-03088-ELR	Docum	nent 448-73	Filed 11/2	29/23	Page 86 of 627
	tensive Customized Care Coordination • Impulsivity • Depression • Anxiety		At least 1 rating of "1" on the following Exposure to Potentially Traumatic/Adverse Childhood Experiences: Sexual Abuse Physical Abuse Neglect Witness to Family Violence Community Violence	aregiving/Attachment Losses	At least 1 rating of "2" or "3" on the following Life Functioning Needs: • Family • Living Situation • Social Functioning • Legal	Sleep Recreational School Behavior And one or more of the following:	1. Individual has shown serious risk of harm in the past one hundred and eighty (180) days, as evidenced by one of the following: a. Indication or report of significant and repeated impulsivity and/or physical aggression, with poor judgment and insight, and that is significantly	

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Case 1:16-cv-03088-E	LR D	ocumei	nt 448-73	Fil	led 11	1/29/23	Page 87 of 627
Intensive Customized Care Coordination 2. The clinical documentation supports the need for the safety and structure of treatment provided the individual's behavioral health issues are unmanageable as evidenced by: a. Documented history of multiple admissions to crisis stabilization programs or psychiatric hospitals (in the past 12 months) and individual has not progressed sufficiently or has regressed; and one of the following: i. Less restrictive or intensive levels of treatment have been treated at high levels of care for artended periods of time; OR ii. Symptoms are persistent and functional ability shows no significant improvement despite extended treatment exposure, OR iii. Symptoms are persistent and functional ability shows no significant improvement despite extended treatment exposure, OR iii. Symptoms are persistent and functional ability shows no significant improvement despite extended treatment exposure, OR iii. Symptoms are persistent and functional ability shows no significant improvement despite extended treatment exposure, OR iverse treated with two or more psychotropic medications at the same time over a 3-month period by the same or multiple prescribing providers, OR d. Youth and/or family risk of homelessness within the prior 6 months. 3. Individual and/or family has history of attempted, but unsuccessful follow through with elements of a Resiliency/Recovery Plan which has resulted in specific mental. Dehavioral or emphysing that place the recipient at imminent risk for disruption of current living arrangement inclinding	a. Lack of follow through taking prescribed medications; b. Following a crisis plan; or c. Maintaining family and community-based integration.	 Individual has shown serious risk of harm due to Mental Health, Substance Use, or Co-Occurring issues in the past ninety (90) days, as evidenced by the following: Some self-mutilation, risk taking or loss of impulse control resulting in danger to self or others, or Decreased daily functioning due to bizarre behavior, psychomotor agitation, or 	• • • •		_	ه آ	c. Transfer to another service is warranted by change in the individual's condition.
Intens			Continuing Stay Criteria			Discharge Criteria	

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Hiterative Customized Care Coordination providers cannot bill the following services while providing theirsive Customized Care Coordination to an individual: Service Paul Development Community Support Individual Research Individual R

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Case 1:16-0	v-03088-ELR	Document 448-73	Filed 11/29/23 Page	e 89 of 627
 12. All staff must be trained in High Fidelity Wraparound through the Georgia Center of Excellence for Child and Adolescent Behavioral Health (COE) before providing this service. 13. Ensure that families are utilizing natural supports and low-cost, no-cost options that are sustainable. Provision of crisis response, 24/7/365 to the individual they serve, to include face-to-face response when clinically indicated. 14. The Care Coordinator will average 3 hours of care coordination per week per individual served. 15. The Care Coordinator will average 1 face-to-face per weekly contact with the CPS-P on the ICCC team in support of the individual/family. 16. To promote team cohesion, Care Coordinators must have weekly contact with the DBHDD Provider Manual for Community Behavioral Health Providers. 17. All coordination will be documented in accordance with the DBHDD Care Management Entity (CME) quality improvement processes. 	 Intensive Customized Care Coordination providers will minimally have: Care Coordinators who can serve at a 10 individual to 1 care coordinator ratio: Care Coordinators who can serve at a 10 individual to 1 care coordinator ratio: Care Coordinators must possess a minimum of B.A or B.S. degree in social work, psychology or related field with a minimum of two (2) years clinical intervention experience in serving youth with SED or emerging adults with mental illness. All Bachelor level and unlicensed care coordinators must be supervised at minimum by a licensed mental health professional (e.g., LCSW, LPC, LMFT). Experience can be substituted for education. Ability to create effective relationships with individuals of different cultural beliefs and lifestyles. Effective verbal and written communication skills. 	2. Wraparo	3. A Progra are critic fidelity: P	
ntensiv		Staffing Requirements		

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Intensive Cu	510	Intensive Customized Care Coordination	
	1.	Providers must adhere to the DBHDD CME Procedures Manual.	
	2	Provider must accept all coordination responsibility for the individual and family.	
	რ.	Provider must ensure that all possible resources (services, formal supports, natural supports, etc.) have been exhausted to sustain the individual in a	
		community-based setting prior to institutional care being presented as an option.	
	4.	Provider must ensure care coordination and tracking of services and dollars spent.	Ca
	5.	Provider must ensure that all updated action plans or authorization plans are submitted to the authorizer of services per the state guidelines of 7 days after the CETM	se 1
Clinical	9	Or Twi. Provider must have an organizational plan that addresses how the provider will ensure the following:	L:1
Operations		 Direct supervision by the supervisor must occur at least monthly utilizing the supervision tools indicated by the National Wraparound Initiative. 	6-c
		 Group/team case consultation by the supervisor must occur at least twice monthly. 	V-(
		 Provision of oversight and guidance around the quality and fidelity of Wrap Process by the supervisor.)30
			88
		 Ungoing training and support from the Center of Excellence regarding introductory and advanced vyraparound components as identified by CME Start, COE or DBHDD in maintaining effective statewide implementation. 	-EL
		 Supervisors complete Georgia Document Review Form (see DBHDD CME Manual) with Care Coordinators monthly for each child and family team. 	.R
		 Provision of crisis response, 24/7/365 to the youth they serve, to include face-to-face response when clinically indicated. 	
	-	Providers will be available for meetings at times and days conducive to the families, to include weekends and evenings for Child and Family Team meetings.	Do
Service	2	Families must be given their choice of family support organizations for parent peer support, where available. If unavailable in their county, the provider of Intensive	CL
Accessibility		Customized Care Coordination must provide parent peer support to the family, as the Wrap Team is defined as a care coordinator and a High-Fidelity	ım
		Wraparound trained certified parent peer specialist (CPS-P).	ent
	The	The following must be documented:	t 4 4
	<u>—</u>	Youth/Young Adult and family orientation to the program, to include family and individual expectations.	1 8-
	2.	Wrap Team progress notes are documented for all individual and family interventions and coordination interventions. These notes adhere to the content set forth	-73
		in the DBHDD Provider Manual for Community Behavioral Health providers.	3
	က် ·	Evidence that the youth/young adult's needs have been assessed, eligibility established, and needs prioritized.	F
Documentation	4. 1	Evidence of youth/young adult participation, consent and response to support are present.	ile
Kequirements	ک	Evidence that methods used to deliver services and supports to meet the basic needs of individual are in a manner consistent with normal daily living as much	ed :
	ď	as possible. Evidence of minimal narticipation in each CETM as described in Deminiral Components	11/
	· /	Evidence of CETMs and ECETMs occurring as described in Required Components	29
	. wi	Documentation of active CPS-P participation in the team process (billed separately from the ICCC service). If this is declined in accordance with Staffing	/23
		Requirement Item 4 above, the reason for declined CPS-P support is noted in the record.	3
Billipa 8	-	The provider must report data to the DBHDD or COE as required by the DBHDD CME Quality Improvement Plan or any other data request.	Р
Reporting	2		ag
Requirements	ന [്]		e !
	4	The provider must document the provision of direct observation of staff in the field by Master Trainers/Coaches.	90
Additional Medicaid	-	The Care Coordinator is responsible for seeking service authorization in accordance with the criteria herein through the benefit manager.	of 62
Reduirems			27

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Intensive Cu	Intensive Customized Care Coordination: Flexible Supp	nation: Flex	orts	7	::-1×0	(4	
l ransaction Code	Code Detail	Code Mod	Mod Mod 2	Mod Kate 4	Code Detail	Code	Mod 1	Mod 2	3 3	Mod 4	кате	
	Behavioral Assistance	TBD			Customized Goods and Services							
	Clinical Consultative	TBD			Respite	TBD						Ca
	Expressive Therapeutic	TBD									ast	ase
Unit Value	Varied (See below)				Maximum Daily Units	Varied	Varied (See below)	(w				e 1
	The ICCC service is based on several mandatory elements v "whatever it takes" to promote health, wellness, and recovery service guideline or can be accessed through the community includes local non-profit resources (which may include a fam of other creative solutioning for the child.	several mandat health, wellness sessed through t ces (which may r the child.	ory elements which is, and recovery for the community and the include a family sup	comprise fidelity le youth and fan eam resources i	The ICCC service is based on several mandatory elements which comprise fidelity to the wraparound model. Philosophically, the wraparound approach calls for doing "whatever it takes" to promote health, wellness, and recovery for the youth and family. The "whatever it takes" supports can be reimbursed by the DBHDD through this service guideline or can be accessed through the community and team resources that are developed in partnership with the unique child/family team members. This includes local non-profit resources (which may include a family support organization), church resources, family/friend volunteers, professional resources, and a myriad of other creative solutioning for the child.	sophically, the orts can be re with the unic unicers id volunteers	e wraparo eimbursec que child/f professic	und appr I by the E amily tea mal reso	oach ca DBHDD Im mem urces, a	lls for dc through bers. Th nd a my	<u>ත .ග</u>	L:16-cv-0308
	ICCC Flexible Supports is an adjunct to ICCC, and is comprised of the following availabl Consultative Services, Expressive Therapeutic Services, and Respite, as defined below:	adjunct to ICCC, sive Therapeutic	and is comprised of Services, and Resp	the following avite, as defined b	ICCC Flexible Supports is an adjunct to ICCC, and is comprised of the following available support: Behavioral Assistance, Customized Goods and Services, Clinical Consultative Services, Expressive Therapeutic Services, and Respite, as defined below:	stance, Custc	mized Go	ods and	Service	s, Clinica		8-ELR
	1. Behavioral Assistance: P and as specified in the pl	Provided to suppulan of care. Serv	ort the individual in t ices may be rendere	he community a	Behavioral Assistance: Provided to support the individual in the community and promote independence in daily activities, as appropriate to the participant's needs and as specified in the plan of care. Services may be rendered in the participant's home or community setting as documented in the plan of care. Services may	y activities, a as documer	s appropr ted in the	iate to th plan of c	e partici are. Ser	pant's n	sp	Doc
	include, but are not infilted to: a. Assisting the youth/par. b. Assistance in daily livin	ed to: :h/parent/caregiv y living, such as	, but are not infined to: Assisting the youth/parent/caregiver in organizing a safe household environment; Assistance in daily living, such as household tasks related to building self-sufficiency;	afe household en ated to building	nvironment; self-sufficiency;						umem	ument
	c. Protective oversig d. Providing training	tht and behavior and supervision	Protective oversight and behavioral supervision/redirection; and/or Providing training and supervision for youth to promote social skills	ction; and/or e social skills, p	Protective oversight and behavioral supervision/redirection; and/or Providing training and supervision for youth to promote social skills, problem-solving, coping, life skills, and personal wellbeing as identified in the youth's	and persona	ıl wellbein	g as ider	ntified in	the yout		: 448-
Service Definition	approved Individualized Recovery Plan. Customized Goods and Services: Individualized Goods	services: Individual	Plan.	t vouth with sev	rts that volith with severe emotional dysregulation or mental illness may need to fully benefit from mental	sseulli letue	may need	to fully b	rijened	nem mo		-73
		ss services, equi	ipment, or supplies r Services may include	not otherwise av e tutoring, paren	health services. It includes services, equipment, or supplies not otherwise available to the youth/family and that address an identified need in the Individualized Recovery Plan. Customized Goods and Services may include tutoring, parenting skills, homemaker services, structured recreation, therapeutic activities, mentor	at address ar	identified reation, 1	I need in therapeur	the Indi	vidualize ties, mel		File
	aid, a utility deposit to sta Clinical Consultative Sen	abilize crisis, and vices: Clinical Co	d environmental moc onsultative Services	lification to enha are provided by	aid, a utility deposit to stabilize crisis, and environmental modification to enhance safety in a living arrangement. <u>Clinical Consultative Services</u> : Clinical Consultative Services are provided by professional experts in fields such as psychology, social work, counseling, behavior	nt. ch as psycho	logy, soci	al work, o	counseli	ng, beha		d 11/
	management and/or crim differentiate assessment	inology. These treatment or pl	specialized services	are provided to	management and/or criminology. These specialized services are provided to youth who have specialized diagnoses/needs which may require an expert to differentiate assessment treatment or plans of care. Clinical Consultative Services are services that are not covered by another DBHDD benefit but which are	inoses/needs	which man	ay require	e an exp	ert to		29/2
	necessary to improve the	participant's inc	dependence and inc	lusion in their co	necessary to improve the participant's independence and inclusion in their community, and to assist unpaid caregivers and/or paid support staff in carrying out	aregivers and	/or paid s	upport st	aff in ca	rrying or	`	3
	Individualized Recovery support to carry out the pand Family Team meeting	Plans (IRPs). Se blan, monitoring os Crisis comos	ervices may include of the participant and eling and stabilization	assessment, der d other provider on and family or	Individualized Recovery Plans (IRPs). Services may include assessment, development of a home treatment/support plan, training, technical assistance and support to carry out the plan, monitoring of the participant and other providers in the implementation of the plan, and remise may be provided. This service may be delivered in the	upport plan, in, and comp	training, te ensation f	echnical a or partici	assistan pation ir	ce and າ the Chi in the		Page
	youth's home, other com	munity home su	ch as foster care, in	the school, or ir	youth's home, other community home such as foster care, in the school, or in other community settings as described in the IRP to improve consistency across	scribed in the	IRP to in	prove co	onsisten	cy acros		91
	service systems. 4. Expressive Therapeutic service help participants find a for	Services: An adji	unct therapeutic mode beyond words or the	dality to support	service systems. Expressive Therapeutic Services: An adjunct therapeutic modality to support individualized goals as part of IRP. The aim of creative therapeutic modalities is to help participants find a form of expression beyond words or traditional therapy. They include techniques that can be used for self-expression and personal growth	P. The aim c	of creative	therapeu	utic mod	alities is sonal ar		of 627
	and aid in the healing an	d therapeutic pro	ocess. Services may	include, but are	and aid in the healing and therapeutic process. Services may include, but are not limited to the following: Art Behavioral Services, Dance/Movement Behavioral	Sehavioral Se	ervices, Di	ance/Mo	vement	Behavio	— I	•

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Intensive Co	ustomize	Intensive Customized Care Coordination: Flexible Supports
		b. The specific Customized Goods and Services must be clearly linked to a participant behavior/skill/resource need that has been documented in the
		approved IRP prior to purchase or delivery of services.
		c. Goods and services purchased under this coverage may not circumvent other restrictions of services, including the prohibition against claiming for
		The costs of room and board.
		 a. The care coordinator may provide support to the participant/representative in budgeting and directing goods or services to be purchased that will include the supplier/vendor name and identifying information and the cost of the service/goods.
	3. Respite:	ig
	-	a. Respite is available twenty-four (24
		 b. Respite Services may be in quarter-hour increments or overnight, and may be provided in-home or out-of-home in the following locations: (1) Participant's home or private place of residence. (2) The private residence of a respite care provider. (3) Foster home/Group home.
	'	A variety of staff may provide ICCC-FS, in accordance with scope of practice and other requirements below.
	2. The IC	l he ICCC Provider is responsible for assuring that the professional is credentialed/licensed/certified to provide the service offered. The following are staffing requirements specific to certain ICCC Flexible Supports services:
	ш,	
		a. Individual providing the service is at least 21 years of age, or if exceptional circumstances exist (for example in rural areas, or the age requirement
		presents a natustrip in a participant being able to access program services) a person 10-20 years of age may provide this service. b. Individual has current CPR and Basic First Aid certifications:
		person is free of communicable diseases;
		d. Individual has the experience, training, education or skills necessary to meet the participant's needs for Wraparound Services as demonstrated by
		experience in providing direct assistance to maividuals with menas to network within a local community of comparable naming, education of skills;
		e. Individual agrees to or provides required documentation of a criminal records check, prior to providing services;
į		f. Individual has an understanding of Wraparound Services and strategies for working effectively/communicating clearly with people who have a
Staffing		mental illness and their families/r
Kequirements		g. Individual will adhere to UBHUD provider requirements as specified either through UBHUD contract with the Medicaid enrolled provider or a Letter of
	5. Clinica	Agreement between the medical emoned provider and DD1 DD. Clinical Consultative Services:
		a. Professionals delivering Clinical Consultative Services shall meet all applicable licensure and certification requirements, and adhere to Georgia law
		b. May be provided by a licensed physician, psychologist, LCSW, LMSW, LPC, LAPC, LMFT, LAMFT, RN, CAC-II, CAADC, MAC, or GCADC-II.
	o. Expre	
		a. Frodessionals delivering official consultative set vices shall nieet all applicable licensule and centification requirements, and adnere to security and the scope of practice definitions of licensulte hoards:
		b. May be provided by an LCSW, LMSW, LPC, LAPC, LMFT, LAMFT, RN, psychologist or psychologist supervisee, CAC-I (at least Bachelor's), CAC-
		II, CAADC, MAC, GCADC-I (at least Bachelor's), GCADC-II, or Addiction Counselor Trainee with at least a Bachelor's degree in a helping
		profession; and
		c. To provide a particular Expressive Therapeutic Service a provider shall have current registration in the applicable Association as follows:
		 Art Behavioral Services – Current registration in the American Art Therapy Association as a Registered Art Therapist by the Art Therapy Cradontials Board or a comparable Association with equivalent requirements:
		Ciedentias board of a comparable Association will equivalent lequirents,

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Example Services Control Respitation of the American Political Processive Services - Current registration as a Darce Theraptist Registered or an Academy of Darce Theraptist Secretarion Processing of Count and Learning Secretarion Darce Theraptist Secretarion with equivalent requirements; in Market and Count and Learning Secretarion Darce Theraptist Secretarion with equivalent requirements; in Market Association (EGALA); and the Association with equivalent requirements; in Market Association and Learning Secretarion Darce Theraptist Secretarion and Learning Secretarion Darce Theraptist Secretarion with equivalent requirements; in Mass Theraptism, c. in the American Horizontal Darce Behavioral Services - Current registration as a Market Theraptism Co. C. A. Title 43, by the Beard for Mass Theraptism, c. in the American Horizontal Darce Behavioral Services - Current registration in the National Association with equivalent requirements; in Pagorian Darce Association with equivalent requirements; in Pagorian Darce Behavioral Services - Current Registration as provider of a registered of the Parapty County of the American Horizontal Darce Behavioral Services - Current Registration as provider of a registered Anneal Therapty Team through a registered Darna Association with equivalent equirements; in Register Darce Provider of a registered Anneal Therapty Team through a registered Darna Association with equivalent equirements; in Register Darce Provider of an engineered Anneal Therapty Team through a registered Darna Association of the organization of the provider and the youth in their care. It is applicable for MFP waver patricipants of the family the respit providers must have a reliable behavior communication. 1. Registe providers must have a reliable deliboring communication. 2. Registe providers must have a rel

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Intensive Cu	Intensive Customized Care Coordination: Flexible	n: Flex	ible S	e Supports	rts								
Additional	1. Non-MFP enrolled Medicaid youth may receive these DBHDD state-funded services, as Medicaid does not reimburse these supports (the encounters are	th may rec	seive the	se DBF	IDD state	-funded ser	vices, as Me	edicaid does not reimburs	se these s	upports	(the en	counters a	re
Medicaid Requirements	submitted to the Georgia Collaborative ASO). 2. For youth enrolled in the Medicaid MFP program, these services should be billed directly to DCH	orative AS0 id MFP pro	O). ogram, 1	hese se	rvices sh	ould be bille	ed directly to	DCH.					
Intensive Fa	Intensive Family Intervention						,						
Transaction Code	Code Detail	Code	Mod 1	Mod 2	Mod M	Mod Rate 4	Code Detail	tail	Code	Mod 1	Mod 2	Mod Mod 3 4	d Rate
	Practitioner Level 3, In-Clinic	H0036	U3	90		\$30.01		Practitioner Level 3, Out-of-Clinic	H0036	C)	U2		\$41.26
	Practitioner Level 4, In-Clinic	H0036	1 1	90		\$22.14	+	Practitioner Level 4, Out-of-Clinic	H0036	4	U2		\$27.06
: L	Practitioner Level 5, In-Clinic	H0036	U2	9N		\$16.50	_	Practitioner Level 5, Out-of-Clinic	H0036	U2	10		\$20.17
Intensive Family Intervention	Practitioner Level 3, via interactive audio and video telecommunication systems	H0036	GT	U3		\$30.01		Practitioner Level 5, via interactive audio and video telecommunication systems	H0036	GT	US		\$16.50
	Practitioner Level 4, via interactive audio and video telecommunication systems	H0036	GT	N4		\$22.14	4						
I Init Value	15 minutes						I Hilization	Hilization Criteria	TRD				
	A service intended to improve family functioning by clinically stabilizing the living arrangement, promoting reunification or preventing the utilization of out of home therapeutic venues (i.e. psychiatric hospital, psychiatric residential treatment facilities, or residential treatment services) for the identified youth. Services are delivered utilizing a team approach and are provided primarily to youth in their living arrangement and within the family system. Services promote a family-based focus in order to:	functioning ospital, psy ovided prim	g by clir ychiatric narily to	ically st resider youth ir	abilizing that treatrestruction that the contraction that the contractio	ne living ari nent facilitii ig arranger	angement, ps. or resider	clinically stabilizing the living arrangement, promoting reunification or preventing the utilization of out of home atric residential treatment facilities, or residential treatment services) for the identified youth. Services are delivent to youth in their living arrangement and within the family system. Services promote a family-based focus in o	preventir or the ide rvices pro	ig the ut ntified y mote a	tilizatior routh. S family-k	of out of hervices are	ome delivered s in order
	 Defuse the current behavioral health crisis, evaluate its nature and intervene to reduce the likelihood of a recurrence; Ensure linkages to needed psychiatric, psychological, medical, nursing, educational, and other community resources, including appropriate aftercare upon discharge (i.e. medication, outpation) and other community resources. 	ral health c	risis, ev.	valuate i	ts nature a medical,	and interve nursing, ec	ne to reduce lucational, al	the likelihood of a recurr nd other community reso	ence; urces, inc	luding a	ıppropri	ate afterca	re upon
Service Definition	 Improve the individual child's/adolescent's capacity to care for their children. 	supauent 's/adolesce ildren.	appoint ent's ab	llity to se	elf-recogn	ize and sel	-manage be	niments, etc.), and ability to self-recognize and self-manage behavioral health issues, as well as the parents/responsible caregivers'	s well as t	he pare	nts'/res	ponsible ca	aregivers'
	Services should include crisis intervention, intensive supporting resources management, individual and/or family counseling/training, and other rehabilitative supports to prevent the need for out-of-home placement or other more intensive/restrictive services. Services are based upon a comprehensive, individualized assessment and are directed towards the identified youth and his or her behavioral health needs/strengths and goals as identified in the Individualized Resiliency Plan.	ention, inter cement or and his or	nsive su other m her beh	pportino ore inte avioral	g resource nsive/rest health ne	ss manager rictive serv eds/strengt	nent, individices. Service sand goals	e supporting resources management, individual and/or family counseling/training, and other rel er more intensive/restrictive services. Services are based upon a comprehensive, individualized behavioral health needs/strengths and goals as identified in the Individualized Resiliency Plan.	ing/trainin prehensiv idualized I	ig, and o e, indivi Resilien	other re idualize cy Plan	habilitative d assessm	supports to ent and are
	Services shall also include resource coordination/acquisition to achieve the youth's and their family's' goals and aspirations of self-sufficiency, resiliency, permanency, and community integration.	coordinatic	on/acqu	isition to	achieve	he youth's	and their fan	nily's' goals and aspiratio	ins of self-	-sufficie	ncy, res	iliency, pe	rmanency,
Admission Criteria	 Youth has a diagnosis and duration of symptoms which classify the illness as SED (youth with SED have a diagnosable mental, behavioral, or emotional disorder of sufficient duration to meet DSM diagnostic criteria and results in a functional impairment which substantially interferes with or limits the child's role or functioning in the family, school, or community activities) and/or is diagnosed with a Substance Related Disorder; and one or more of the following: Youth has received documented services through other services such as Non-Intensive Outpatient Services and exhausted these less intensive out-patient resources. Treatment at a lower intensity has been attempted or given serious consideration, but the risk factors for out-of-home placement are compelling (see 	ation of syr SM diagno I, or comm ed services	nptoms stic crit unity ac throug has bee	which ceria and stivities) hothers	lassify the results in and/or is services s	e illness as a functiona diagnosed uch as Nor ven serious	SED (youth al impairmen with a Subst-Intensive O	with SED have a diagnor t which substantially inter ance Related Disorder; a outpatient Services and e on, but the risk factors fo	sable men rferes with Ind one o xhausted r out-of-ho	ital, beh i or limit r more these le these le	lavioral, s the cl	or emotion nild's role o ollowing: ollowing: sive out-p	nal disorder r atient elling (see

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intensive ramily intervention (item G.1. below);	Á	INCENCENTION item G.1. below); The less intensive services previously provided must be documented in the clinical record (even if it via by self-report of the youth and family);
		Or and the state of the state o
	ധ. 4	Youth and/or family has insufficient or severely limited resources or skills necessary to cope with an immediate behavioral health crisis; or Youth and/or family behavioral health issues are unmanageable in traditional outhatient treatment and require intensive coordinated clinical and supportive
	÷	intervention; or
	6.5	Because of behavioral health issues, the youth is at immediate risk of out-of-home placement; or Because of behavioral health issues, the youth is at immediate risk of legal system intervention or is currently involved with DJJ for behaviors/issues related to
		SED and/or the Substance-related disorder.
Continuing Stay Criteria	Sam	Same as above.
	← c	An adequate continuing care plan has been established; and one or more of the following:
Discharge	vi c	Youtn no longer meets the admission criteria; or Gasts of the Individualized Resiliency Plan bave been substantially met: or
Criteria	. 4	Individual and family request discharge, and the individual is not imminently dangerous; or
	ري ص	Transfer to another service is warranted by change in the individual's condition; or individual requires services not available within this service
	-	Not offered in conjunction with Individual Counseling, Family Counseling/Training, Crisis Intervention Services, and/or Crisis Stabilization Unit, PRTF, or
		inpatient hospitalization.
	۲.	Community Support may be used for transition/continuity of care.
	က်	This service may not be provided to youth who reside in a congregate setting in which the caregivers are paid (such as group homes, or any other living
		environment that is not comprised of ramily, guardians, or other more permanent caregivers). A short-term exception would be in the youth were preparing for transition back to a single-family unit, the family member is present during the intervention, and the service is directed to supporting the unification/reunification
Service		of the youth and his/her identified family/caregiver and takes place in that home and community.
Exclusions	4	The absence of empirical evidence for conversion therapy prohibits the use of this intervention and it is not reimbursed by DBHDD.
	2.	The billable activities of IFI do not include:
		 Transportation;
		 Observation/Monitoring;
		• Tutoring/Homework Completion; and
		 Diversionary Activities (i.e. activities without therapeutic value).
Clinical	.	Youth with any of the following unless there is clearly documented evidence of an acute psychiatric/substance use disorder episode overlaying the diagnosis: Autism Spectrum Disorders including Asperger's Disorder, Intellectual/Developmental Disabilities, Neurocognitive Disorder; or Traumatic Brain Injury.
Exclusions	2	Youth can effectively and safely be treated at a lower intensity of service. This service may not be used in lieu of family preservation and post-adoption services
	-	Tor you'm who do not meet the admission criteria for IFI.
	-, ~;	The organization has procedures/protocols for emergency/crisis situations that describe methods for intervention when youth require psychiatric hospitalization. Each IFI provider must have policies and procedures governing the provision of outreach services, including methods for protecting the safety of staff that engage
Dogminod		in outreach activities.
Components	က်	The organization must have an Intensive Family Intervention Organizational Plan that addresses the description of:
		 Particular evidence-based family preservation, resource coordination, crisis intervention and wraparound service models utilized (MS1, DB1, MDF1, etc.), types of intervention practiced. The organization must show documentation that each staff member is trained in the model for in-home treatment (i.e.,
		certification, ongoing supervision provided by the training entity, documentation of annual training in the model);

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Intensive Family Intervention

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Intensive Family Intervention

≥.

- Be dedicated to a single IFI team ("Dedicated" means that the team leader works with only one team at least 32 hours/week [up to 40 hours/week] and is a full-time employee of the agency [not a subcontractor/1099 employee]). The Team Leader is available 24/7 to IFI staff for emergency consultation/supervision
- Two to three fulltime equivalent paraprofessionals who work under the supervision of the Team Leader.
- The team may also include an additional mental health professional, addiction professional or paraprofessional. The additional staff may be used .25 FTE ن ف
- Physician, Psychiatrist or a Licensed Psychologist (via contract or referral agreement). These contracts/agreements must be kept in the agency's administrative To facilitate access for those families who require it, the specialty IFI providers must have access to psychiatric and psychological services, as provided by a files and be available for review. S
- examples of best/evidence-based practice are multi-systemic therapy, multidimensional family therapy, dialectic behavioral therapy and others as appropriate to chosen by the organization. There shall be training documentation indicating the evidenced-based in-home practice model each particular staff person will be the child, family and issues to be addressed. Their personnel files must indicate documentation of training and/or certification in the evidenced-based model Practitioners providing this service are expected to maintain knowledge/skills regarding current research trends in best/evidence-based practices. Some utilizing in the provision of services. ന
 - (which is the maximum limit which shall not be exceeded at any given time). The staff-to-family ratio takes into consideration evening and weekend hours, needs The IFI Team's family-to-staff ratio must not exceed 12 families for teams with two paraprofessionals, and 16 families for teams with three paraprofessionals of special populations, and geographic areas to be covered. 4.
- counseling and treatment modalities/interventions needed by the individual and must provide these modalities/interventions as clinically appropriate according to Documentation must demonstrate that at least 2 team members (one of whom must be licensed/credentialed) are providing IFI services in the support of each ndividual served by the team in each month of service. One of these team members must be appropriately licensed/credentialed to provide the professional 5
 - team members. Team members must work for only one IFI organization at a time and cannot be providing this service when they are a member of another team It is critical that IFI team members are fully engaged participants in the supports of the served individuals. No more than 50% of staff can be "contracted"/1099 because they cannot be available as directed by families need or for individual crises while providing on-call services for another program. 9
- When a team is newly starting, there may be a period when the team does not have a "critical mass" of individuals to serve. During this time, a short-term waiver paraprofessionals serving less than individual-load capacity. For example, a team may only start by serving 4-6 families (versus full capacity 12-16 families) and therefore could request to have the team leader serve 1/2 time and a single paraprofessional. A waiver of this nature will not be granted for any time greater than may be granted to the agency's team by the DBHDD for the counties served. The waiver request may address the part-time nature of a team leader and the 6 months. The waiver request to DBHDD must include: 7.
 - The agency's plan for building individual capacity (not to exceed 6 months).
- DBHDD has the authority to approve these short-term waivers and must copy BHO on its approval and/or denial of these waiver requests. No extension on The agency's corresponding plan for building staff capacity which shall be directly correlated to the item above. hese waivers will be granted.
- licensed/credentialed professional to provide supervision, therapy, oversight of Individualized Recovery/Resiliency Plans, and team coordination. Understanding It is understood that there may be periodic turn-over in the Team Leader position; however, the service fails to meet model-integrity in the absence of a this scenario, an IFI team who loses a Team Leader must provide the critical functions articulated via one of the following means: ω.
 - Documentation that there is a temporary contract for Team Leader who meets the Team Leader qualifications; or
- providing the Team Leader functions temporarily (this would reduce the team staff to either 2 or 3 members based on the numbers of families served by the Documentation that there is another fully licensed/credentialed professional who meets the Team Leader qualifications and is currently on the team

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Intensive Fa	Intensive Family Intervention 11. Service delivery should be organized in a way such that there is a high frequency of services delivered at the onset of support and treatment and a tapening off as the youth moves toward discharge. As it applies to the specific youth, this shall be documented in the record.	
	 Services must be available 24 hours a day, 7 days a week, through on-call arrangements with practitioners skilled in crisis intervention. A team response is preferable when a family requires face-to-face crisis intervention. Due to the intensity of the service, providers must offer a minimum of 3 contacts per week with the youth/family except during periods where service intensity is being tapered toward the goal of transition to another service or discharge. 	Case
		1:16-cv-03
Service Accessibility	5. Services provided for over 6 hours on any given day must be supported with rigorous reasons in the documentation. Anything over 6 hours would need to relate to a crisis situation and the support administrative documentation should spell out the reasons for extended hours and be signed by the Team Leader. 6. To promote access, providers may use Telemedicine as a tool to provide direct interventions to individuals for whom English is not their first language. Examples of this include:	088-ELR
	 the use of one-to-one service intervention via Telemedicine, connecting the individual to a practitioner who speaks the individual's language versus use of interpreters; and/or the use of an interpreter via Telemedicine to support the practitioner in delivering the identified service. 	Docun
	Telemedicine may only be utilized when delivering this service to an individual for whom English is not their first language. The individual/family must consent to the use of this modality. This consent should be documented in the individual's record. The use of telemedicine should he driven by the practitioner's/agency's convenience or preference.	nent 448
Documentation Requirements	 If admission criteria #2 is utilized to establish admission, notation of other services provision intensity/failure should be documented in the record (even if it is self-reported by the youth/family). As the team, youth, and family work toward discharge, documentation must indicate planning with the youth/family for the supports and treatment needed post-discharge from the IFI service. Referrals to subsequent services should be a part of this documentation. 	3-73 Fil
Billing & Reporting Requirements	When Telemedicine technology is utilized for the provision of this service in accordance with the allowance in the Service Accessibility section of this definition, the code cited in the Code Detail above with the appropriate GT modifier shall be utilized in documentation and claims submission.	led 11/2
		9/23

Mobile Crisis	S													
Transaction Code	Code Detail	Code	Mod	Mod Mod	Mod Mod Mod Mod	Mod 4	Rate	Code Detail	Code Mod Mod Mod Mod	Mod	Mod	Wod 8	Mod 4	Rate
Mobile Crisis Response Service				1	,					-	1	,	-	
Service	The Mobile Crisis Response Service (MCRS) provides community-based face-to-face rapid response to individuals in an active state of crisis. This service operates 24 hours a day, seven days a week. MCRS offers short-term, behavioral health, intellectual/developmental disability, and/or Autism Spectrum Disorder (ASD) crisis	(S) provides fers short-t	s comm erm, be	unity-b; haviora	ased far	ce-to-fa 1, intelle	ace rapid re ctual/deve	ssponse to individuals in ar lopmental disability, and/or	active sta Autism S	ate of cr pectrun	risis. Thi n Disorc	is servid der (ASI	e opera	tes 24
Definition	response for individuals in need of crisis assessment, intervention, and referral services within their community. This service is unique in that it provides in-person intheir community who may be in crisis. MCRS may be provided in community settings including, but not limited to homes, residential setti	ssessment, who may be	intervel e in cris	ntion, a is. MCF	nd refer	rral ser be pro	vices withir	t, intervention, and referral services within their community. This service is unique in that it provides in-person be in crisis. MCRS may be provided in community settings including, but not limited to homes, residential settings,	vice is unio, but not li	que in t mited to	hat it pro homes	ovides i s, reside	n-persor Intial set	ر tings,

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nclude interviews with the individual, care providers and/or family members, observation of the current environment, and review of behavior and individual support plans if available. The licensed professional or BCBA on the team is responsible for ensuring that the assessment process is thorough and complete.

- individual/family/caregivers in a therapeutic plan that fosters a return to pre-crisis level of functioning and connect or reconnect the individual to treatment services A crisis plan will be developed to help manage, prevent, or reduce the frequency of future crises occurring. When available, an individual's existing crisis plan should be utilized by the MCRS team when it is appropriate to the presenting situation. When a crisis plan does not exist, MCRS will engage the and other community resources. 5.
- Also, when available and offered by the individual, a Wellness Recovery Action Plan (WRAP) shall be utilized by MCRS to support the individual's preferences.
- When available, an individual's behavior support plan shall be utilized by MCRS during the assessment process.
- All interventions shall be offered in a clinically appropriate manner that respects the preferences of the individual in crisis while recognizing the primary need to maintain safetv. 6
- Reasonable and relatively simple environmental modifications that do not require continuing programmatic efforts are considered before intensive crisis supports and/or a behavior plan is recommended or implemented.
 - When applicable and accessible, community supports, natural supports, and external helping networks should be utilized for crisis planning to assist in crisis œ.
 - (e.g., Provider Agencies Families/Caregivers/ Guardians, Support Coordination Agencies, known Care Coordinators and/or Regional Field Office I&E Teams as When the Mobile Crisis Team makes a disposition, the licensed clinician or BCBA communicates all recommendations within 24 hours to all applicable parties <u>ග</u>
- The MCRS shall comply with the current GCAL process for dispatch of mobile crisis, including non-refusal of calls or dispatch. 6. 7.
- When the Mobile Crisis Team completes services, the licensed clinician or BCBA on the team completes a written summary that shall:
 - Minimally include:
- Description of precipitating events
- Assessment and Interventions provided
 - Diagnosis or diagnostic impressions Response to interventions
- Recommendations for continued interventions
- Linkage and Referral for additional supports (if applicable); and
- Be completed and documented within a 24-hour period after a disposition has been determined.
- representative/parent/guardian. Exceptions to this requirement are for persons for whom the mobile crisis intervention results in placement in a hospital, CSU, Within 24 hours of completion of the MCRS intervention a follow-up phone call is made and documented to individuals served or their BHCC, intensive in-home IDD supports, or an IDD crisis home.
- The MCRS provider must develop policies and procedures consistent with DBHDD policies for referral and engagement with Crisis Stabilization Units (CSUs) Behavioral Health Crisis Centers (BHCCs), Crisis Respite Homes and In-Home IDD Supports; (i.e., staffing, eligibility, service delivery, GCAL interface) 33
- Additionally, the MCRS provider must develop policies and procedures that include criteria for determination of the need for higher levels of care, indicators for referral to medical/health services and how staff should access support from healthcare professionals; how the staff will be trained to employ positive behavior supports, trauma informed care, and crisis intervention principles in the delivery of mobile services; and how the safety of staff members is maintained. 4.
- Specialty providers, Detoxification providers, IDD service providers, local physicians, BHCCs/CSUs, and other public and social service agencies (such as DFCS, MCRS will collaborate with the individual's health and support providers to ensure linkage with follow-up post crisis treatment. This may include Core providers, schools, treatment courts, law enforcement, Care Management Organizations [CMOs], etc.). When the MCRS provider determines during a community-based ntervention that an individual is enrolled with a CMO, the CMO will receive notification within 72 hours through an identified inbox and provided basic status 15.

	information (name, date of intervention, written summary, final referral and disposition, for the CMO to follow up on treatment services and other community
	resources for the member. 16. The MCRS must maintain accreditation by the appropriate credentialing body (The Joint Commission, The Commission on Accreditation of Rehabilitation
	Facilities, The Council on Accreditation).
	1. The following training components must be provided during orientation for all new staff:
	• Community-based crisis intervention training and TIP 42 training.
	• UBHDD array of Adult Mental Health, Child and Adolescent Mental Health, Addictive Diseases, Intellectual & Developmental Disabilities crisis services, and
	community psychiatric nospitals.
	Dispatch decision free.
	Web-based data access and interface with DBHDD information system.
	2. The Mobile Crisis Team includes minimally two staff responding:
	a. Of those, one (1) is a Licensed Clinical Social Worker/Licensed Professional Counselor/Licensed Marriage and Family Therapist/ Licensed Psychologist
Staffing	(LCSW/ LPC/LMFT/Licensed Psychologist Ph.D./Psy.D.); and
Requirements	b. When the screening indicates that the individual in crisis has IDD, the two-person team must also include a Behavioral Specialist (BS), BCBA, or BCaBA
	(dispatch of a licensed clinician is always required along with this practitioner).
	c. Additional staff who may be dispatched when a behavioral health need is identified include: paraprofessional/direct support staff, a registered nurse, an
	additional social worker (MSW), safety officer, and/or a Certified Peer Specialist (CPS, CPS-AD, CPS-Y, and CPS-P)].
	e. Each mobile crisis team must include at least one stair member with specialization in ASD; so, when there is a known of suspected indication of ASD, the
	rollowing team compositions are allowed: i - A BCBA or BCBA-D who serves as the lead in a mobile crisis response for individuals with ASD and any second recognized practitioner type pamed
	3. All team members are required to comply with the Professional Licensing or Certification Requirements and the Reporting of Practice Act Violations, 04-101,
	1. MCRS must be available by staff skilled in crisis intervention 24 hours a day, 7 days a week with emergency response coverage, including psychiatric, medical and
	_
	2. All mobile crisis service response times for arrival at the site of the crisis must be less than 59 minutes of disparch by the GCAL.
Service	
Accessibility	4. MCRS may not be provided in an institution for Mental Diseases (IMD, e.g., treatment units for state or private psychiatric hospital, psychiatric residential treatment
	lacinity of class stabilization program, making tronges your development certical (TDC), or state it issues. Telemedicine is the use of medical information exchanged from one site to another via electronic communications to improve a patient's health. Electronic
	O
	interactive communication between the patient, and the physician or practitioner at the distant site. Telemedicine is never to be utilized as the primary means of
	delivery of MCRS services.

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		_
	1. Providers must document services in accordance with the specifications for documentation requirements specified in Part II, Section IV of the Provider Manual and	
	in keeping with this section G. Documentation will include the following;	
	• Calls received;	
	 Referring source; individual, agency, 	C
	Time of received call,	cas
	Specific plan of action to address need;	se
	Composition of responders	1:
;;;;;;;;;;;;;;;;;;;;;;;;;;;;;;;;;;;;;;	 Time of arrival on-site 	16
Documentation	 Time of completion of assessment 	-C'
sillellle linhau	Description of intervention,	v-(
	Diagnosis and or diagnostic impressions)3(
	 Documentation of disposition, linkages provided/appointments made 	380
	 Behavioral recommendations provided; 	8-I
	Provision of assessment upon Release of Information	ΞL
	Contact information for follow-up	R
	• Follow-up contact.	
	2. Each MCRS shall provide monthly outcomes data as defined by the DBHDD.	D
Billing &	1. All other applicable DBHDD reporting requirements must be followed.	OCI
Reporting	2. Where there are individuals covered by Georgia CMOs and the specific CMO is identified, the MCRS provider will report the MCRS intervention to the CMO.	um
Requirements		en
		t 448
Parent Peer	Parent Peer Support Service - Group	3-7
Transaction	Code Detail Code Mod Mod Mod Mod Deta Code Detail Code Mod Mod Mod Deta	3

Parent Peer	Parent Peer Support Service - Group	a												
Transaction Code	Code Detail	Code	Mod Mod 1 2		Mod Mod 3 4	Mod 4	Rate	Code Detail	Code	Mod 1	Mod Mod Mod Mod 1 2 3 4	Mod 3	Mod 4	Rate
Peer Support	Practitioner Level 4, In-Clinic	H0038	HQ	HS	U4	90	\$17.72	Practitioner Level 4, Out-of-Clinic	H0038	Ř	HS	U4	U2	\$21.64
Services	Practitioner Level 5, In-Clinic	H0038	Я	HS	N2	90	\$13.20	Practitioner Level 5, Out-of-Clinic	H0038	쭛	HS	SU.	ZN	\$16.12
Unit Value	1 hour					Utilization Criteria	ion	TBD						
Service Definition	Parent Peer Support (PPS) is a strength-base within their home, school, and community whi service within the scope of their knowledge, li the needs of all family members across sever complement the youth's natural environment. The services are geared toward promoting se interventions: a. Through positive relationships with the b. Assisting with identifying other community and the services are serviced to service and the services are geared toward promoting se interventions:	strength-I ommunity knowledg across se environm promotine promotine ig other co	while p while p le, live of several li ent. g self-e g self-e greef the pommuni	ehabiliti d - expe fe dom: mpowe th provii	ative ser ing recovarience, ains, inc rment or recovaries produced and or	rvice pland ed and ed corpora corpora f the page omotinal al supp	rovided to nese servi tucation. Ting forms arent, enharent, enharents a gaccess a corts that conts that contacts and the services are services and the services and the services and the services are services and the services and the services are services and the services and the services are services are services and the services are services are services are services and the services are services are services are services and the services are services ar	Parent Peer Support (PPS) is a strength-based rehabilitative service provided to parents/caregivers that is expected to increase the youth/family's capacity to function within their home, school, and community while promoting recovery. These services are rendered by a CPS-P (Certified Peer Support – Parent) who is performing the service within the scope of their knowledge, live d - experience, and education. The service exists within a system of care framework and enables timely response to the needs of all family members across several life domains, incorporating formal and informal supports, and developing realistic intervention strategies that complement the youth's natural environment. The services are geared toward promoting self-empowerment of the parent, enhancing community living skills, and developing natural supports through the following interventions: a. Through positive relationships with health providers, promoting access and quality services to the youth/family. b. Assisting with identifying other community and individual supports that can be used by the family to achieve their goals and objectives-; these can include	o increase and Peer Su sare framewing realistic aveloping n sveloping n svelop	the you opport - work ar work ar intervent intervent attural satural sand obj	uth/fami Lenab denab ention s support: jectives	ly's cap () who i les time trategie trategie trategie:-; these	s performs set performs that the fight the fig	function ming the onse to ollowing
	Triends, relatives, and/or religious artiliations.	or religiou.	Sallla	IONS.										

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Parent Peer Support Service - Group

- Assisting the youth and family accessing strength-based behavioral health, social services, educational services and other supports and resources required to assist the family to attain its vision/goals/objectives including:
- Helping the family identify natural supports that exist for the family; and
- Working with families to access supports which maintain youth in the least restrictive setting possible; and
- Working with the families to ensure that they have a choice in life aspects, sustained access to an ownership of their IRP and resources developed.
 - In partnership with the multi-disciplinary team, working with the provider community to develop responsive and flexible resources that facilitate communitybased interventions and supports that correspond with the needs of the families and their youth.

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Interventions are approached from a perspective of lived experience and mutuality, building family recovery, empowerment, and self-efficacy. Interventions are based remaining family centered. All aspects of the intervention acknowledge and honor the cultural uniqueness of each family and the many pathways to family recovery upon respect and honest dialogue. The unique mutuality of the service allows the sharing of personal experience including modeling family recovery, respect, and support that is respectful of the individualized journey of a family's recovery. Equalized partnership must be established to promote shared decision making while

approached as a family journey towards self-management and developing the concept of wellness and functioning while actively managing a chronic behavioral health learning to live life beyond the identified behavioral health condition, focusing on identifying and enhancing the strengths of their family unit as supporters of the youth. As a part of this service intervention, a CPS-P will articulate points in their own recovery stories that are relevant to the obstacles faced by the family of consumers of One of the primary functions of the Parent Peer Support service is to promote family/youth recovery. While the identified youth is the target for services, recovery is condition, which enable the youth to be supported in wellness within his/her family unit. Families are supported by the CPS and by participating group members in behavioral health services and promote personal responsibility for family recovery as the youth/family define recovery.

ongoing implementation and reinforcement of skills learned throughout the treatment/support process. PPS is a supportive relationship between a parent/guardian and The group focuses on building respectful partnerships with families, identifying the needs of the parent/caregiver and helping the parent recognize self-efficacy while necessary to promote engagement and active participation of the family in the supports/treatment/recovery planning process for the youth and assistance with the building partnership between families, communities and system stakeholders in achieving the desired outcomes. This service provides the training and support a CPS-P that promotes respect, trust, and warmth and empowers the group participants to make choices and decisions to enhance their family recovery.

The following are among the wide range of specific interventions and supports which are expected and allowed in the provision of this service:

- Facilitating peer support in and among the participating group family members;
- Assisting families in gaining skills to promote the families' recovery process (e.g., self-advocacy, developing natural supports, etc.);
 - Support family voice and choice by assisting the family in assuming the lead roles in all multi-disciplinary team meetings;
- Listening to the family's needs and concerns from a peer perspective, and offering suggestions for engagement in planning process; 6
 - Providing ongoing emotional support, modeling and mentoring during all phases of the planning services/support planning process; ø.
 - f. Promoting and planning for family and youth recovery, resilience and wellness;
- Working with the family to identify, articulate and build upon their strengths while addressing their concerns, needs and opportunities; 9-
- Helping families better understand choices offered by service providers, and assisting with understanding policies, procedures, and regulations that impact the identified youth while living in the community;
- Ensuring the engagement and active participation of the family and youth in the planning process and guiding families toward taking a pro-active and selfmanaging role in their youth's treatment;
- Assisting the family with the acquisition of the skills and knowledge necessary to sustain an awareness of their youth's needs as well as his/her strengths and the development and enhancement of the family's unique problem-solving skills, coping mechanisms, and strategies for the youth's illness/symptom/behavior management;

Parent Peer	Suppo	Parent Peer Support Service - Group
	ᅶ _:	Assisting the parent participants in coordinating with other youth-serving systems, as needed, to achieve the family/youth goals; As needed, assisting communicating family needs to multi-disciplinary team members, while also building the family skills in self-articulating; needs/desires/preferences for treatment and support with the goal of full family-quided youth-driven self-management:
	Ëċ	Supporting, modeling, and coaching families to help with their engagement in all health-related processes; Coaching parents in developing systems advocacy skills in order to take a proactive role in their youth's treatment and to obtain information and advocate with
	ó	Cultivating the parent/guardian's ability to make informed, independent choices including a network for information and support which will include others who have been through similar experiences:
	ď	Building the family skills, knowledge, and tools related to the identified condition/related symptoms so that the family/youth can assume the role of self-monitoring and self-management; and
	ö	Assisting the parent participants in understanding: i. Various system processes, how these relate to the youth's recovery process, and their valued role (e.g. crisis planning, IRP process); ii. What a behavioral health diagnosis means and what a journey to recovery may look like:
		iii. The role of services/prescribed medication in diminishing/managing the symptoms of that condition and increasing resilience and functioning in living with that condition:
	ٺ	Empowering the family on behalf of the recipient; providing information regarding the nature, purpose and benefits of all services; providing interventions and support and education to a caregiver to ensure that he or she is well equipped to support the youth in service transition/upon
	ώ	discharge and have natural supports and be able to navigate service delivery systems; Identifying the importance of Self Care, addressing the need to maintain family whole health and wellness in order to ultimately support the youth with a
	+	behavioral health condition; Assisting the family participants in self-advocacy promoting family-quided, youth-driven services and interventions:
		Drawing upon their own experience, helping the family/youth find and maintain hope as a tool for progress towards recovery; and Assisting youth and families with identifying goals, representing those goals to the collaborative, multi-disciplinary treatment team, and, together, taking specific
		steps to achieve those goals.
	—— 异 es	PPS is targeted to the parent/guardian of youth/young adults who meet the following criteria: a. Individual is 21 or younger; and
	Ġ.	Individual has a substance related condition and/or mental illness; and two or more of the following : i. Individual and his/her family needs peer-based recovery support for the acquisition of skills needed to engage in and maintain youth/family recovery;
Admission Criteria		or ii. Individual and his/her family need assistance to develop self-advocacy skills to achieve self-management of the youth's behavioral health status; or
		iii. Individual and his/her family need assistance and support to prepare for a successful youth work/school experience; or iv. Individual and his/her family need peer modeling to increase responsibilities for youth/family recovery.
	2. Fo	poses of this service, "family" is defined as the person(s) who live with or provide care to the targeted youth, and may include a parent, guardians, jiving relatives, and foster caregivers.
Continuing Stay Criteria	1. Indi 2. Pro	Individual continues to meet admission criteria; and Progress notes document parent/gamine to goals which the youth/family identified in the Individualized Recovery Plan, but treatment/recovery goals have not yet been achieved.
-	1. An	An adequate continuing recovery plan has been established; and one or more of the following:
Discharge Criteria	ю <u>с</u>	Goals of the Individualized Recovery Plan nave been substantially met, or Individual served/family requests discharge: or

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Parent Peer	Parent Peer Support Service - Group										
Service Exclusions	1. "Family" or "caregiver" does not include individuals who are General support groups which are made available to the 3. If there are siblings of the targeted youth for whom a nee 4. This unique billable service may not be billed for youth winstitutions, or any other living environment that is not co youth were preparing for transition back to a single-family unification/reunification of the youth and his/her identified	t include indare made av ted youth for y not be bille anvironment ion back to a outh and his	viduals v ailable to v whom a d for you that is nc a single-f.	the are e the publ need is a th who re th comprise amily uni	mployec ic to proi specified sides in sed of fa t, the fan ily/careg	I to care for mote educk I, this servin a congregamily, guard mily, guard nily membe	"Family" or "caregiver" does not include individuals who are employed to care for the member (excepting individuals who are identified as a foster parent). General support groups which are made available to the public to promote education and advocacy do not qualify as Parent Peer Support. If there are siblings of the targeted youth for whom a need is specified, this service is not billable unless there is applicability to the targeted youth/family. This unique billable service may not be billed for youth who resides in a congregate setting in which the caregivers are paid in a parental role (such as child caring institutions, or any other living environment that is not comprised of family, guardians, or other more permanent caregivers). A short-term exception would be if the youth were preparing for transition back to a single-family unit, the family member is present during the intervention, and the service is directed to supporting the unification/reunification of the youth and his/her identified family/caregiver and takes place in that home and community.	to are identification are identification. Subjict the transition in a para fers). A short-id the service in the	ed as a findbort. argeted yental role ental role-term excepted is direct	oster parent). outh/family. (such as child caring seption would be if the ed to supporting the	Case 1:
Clinical Exclusions	Individuals with the following conditions are excluded from admission unless there is clearly docudiagnosis: Developmental Disability, Autism, Neurocognitive Disorder, or Traumatic Brain Injury.	ions are excl , Autism, Ne	uded froi urocogni	n admiss tive Diso	ion unle der, or T	ss there is Fraumatic E	Individuals with the following conditions are excluded from admission unless there is clearly documented evidence of a behavioral health condition overlaying the diagnosis: Developmental Disability, Autism, Neurocognitive Disorder, or Traumatic Brain Injury.	avioral health	conditio	n overlaying the	16-cv
Required Components		service at an occialist(s), very an organizate in isolatio this service ttc.) in respon	y given ti while alsc zational p n from th are supp	me must respecti lan which e rest of orted thre	have the ng the g articula the progule or articula the progugh a mily crises	e opportuni roup dynar stes the foll rams/servic ryriad of aç	Individuals participating in the service at any given time must have the opportunity to participate in and make decisions about the person-centered interactions offered by the Certified Peer Specialist(s), while also respecting the group dynamics. The operating agency shall have an organizational plan which articulates the following agency protocols: a. PPS cannot operate in isolation from the rest of the programs/services within the agency or affiliated organization or from other health providers; b. CPS-Ps providing this service are supported through a myriad of agency resources (e.g. Supervisors, internal agency 24/7 crisis resources, external crisis resources, etc.) in responding to youth/family crises.	about the penization or fro	irson-cer om other 24/7 crisi	tered interactions health providers; s resources, external	7-03088-ELR
	3. The CPS-P shall be empowere group setting. 4. The CPS-P must be allowed to	d to convent participate a	e multidis is an equ	ciplinary al practit	team me	eetings reg rtner with a	The CPS-P shall be empowered to convene multidisciplinary team meetings regarding a participating individual's needs and desires as they become known in the group setting. The CPS-P must be allowed to participate as an equal practitioner partner with all staff in multidisciplinary team meetings.	s and desires gs.	s as they	become known in the	Docu
Staffing Requirements	 Services must be provided by a CPS-P; Parent Peer Support services are provided in a structured 1:15 CPS to participant ratio; A CPS-P must receive ongoing and regular supervision by an independently licensed practitioner to inc a. Supervisor's availability to provide backup, support, and/or consultation to the CPS-P as needed; b. The partnership between the Supervisor and CPS-P in collaboratively assessing fidelity to the se successes/challenges; and A CPS-P cannot provide this service to his/her own youth and/or family or to an individual with whom h 	a CPS-P; are provided and regular provide ba- the Supervisid	in a struc supervis ckup, sup sor and C	tured 1:1 ion by ar iport, and iPS-P in	5 CPS t indeper l/or cons collabora	o participal ndently lice sultation to atively asset y or to an i	Services must be provided by a CPS-P; Parent Peer Support services are provided in a structured 1:15 CPS to participant ratio; A CPS-P must receive ongoing and regular supervision by an independently licensed practitioner to include: a. Supervisor's availability to provide backup, support, and/or consultation to the CPS-P as needed; b. The partnership between the Supervisor and CPS-P in collaboratively assessing fidelity to the service definition and addressing implementation successes/challenges; and A CPS-P cannot provide this service to his/her own youth and/or family or to an individual with whom he/she is living.	nd addressin	ıg implen	entation	ment 448-73 F
Clinical Operations Service	 CPS-Ps who deliver PPS shall be involved in proactive n PPS is goal-oriented and is provided in accordance with PPS may be provided at a service site, in the recipient's 	be involved vided in acc ice site, in the	in proacti ordance	ve multi- with the y	disciplini outh's c	ary plannin ollaborative	CPS-Ps who deliver PPS shall be involved in proactive multi-disciplinary planning to assist the youth/family in managing and/or preventing crisis situations; PPS is goal-oriented and is provided in accordance with the youth's collaborative and comprehensive IRP. PPS may be provided at a service site, in the recipient's home, or in any community setting appropriate for providing the services as specified in the recipient's	g and/or preve	renting cr	isis situations; d in the recipient's	Filed 11/
Accessibility Documentation Requirements	behavioral health recovery plan; via telephone (although 50% must be provided face to face) CPS-Ps must comply with all required documentation expectations set forth in this manual CPS-Ps must comply with any data collection expectations in support of the program's implications.	t; via telepho quired docu data collection	mentatio	ugh 50% n expecta ations in	must be ations se support	e provided It forth in th of the prog	behavioral health recovery plan; via telephone (although 50% must be provided face to face, telephonic contacts are limited to 50%) CPS-Ps must comply with all required documentation expectations set forth in this manual. CPS-Ps must comply with any data collection expectations in support of the program's implementation and evaluation strategy.	nited to 50%, strategy.			29/23
Parent Peer Transaction Code	Parent Peer Support Service - Individual Transaction Code Detail C	epo	Mod Mod 1	Wod 3	Mod 4	Rate	Code Detail	Code Mod	Mod 2	Mod Mod Rate	Page 107 o
	Practitioner Level 4, In-Clinic	H0038 H	HS U4	90		\$20.30	Practitioner Level 5, Out-of-Clinic	H0038 HS	SD C	U7 \$18.15	

Parent Peer	Support Service - Individu	al												
Transaction Code	Code Detail	Code	Mod 1	Mod 2	Mod Mod Rate	Mod 4		Code Detail	Code	Mod 1	Mod 2	Code Mod Mod Mod Mod 1 2 3 4	Mod 4	Rate
	Practitioner Level 4, In-Clinic	H0038	HS	- 104 - 104	90		\$20.30	Practitioner Level 5, Out-of-Clinic	H0038 HS	와 오	U5	20	0,	\$18.15

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Parent Peer Support Service - Individual	ual										-	_
Practitioner Level 5, In-Clinic H0038 HS U5 U6	HS N5	U5		90		\$15.13	Practitioner Level 4, Via interactive audio and video telecommunication systems	H0038	GT	HS	U4	\$20.30
Practitioner Level 4, Out-of-Clinic H0038 HS U4 U7	HS U4	U4		10		\$24.36	Practitioner Level 5, Via interactive audio and video telecommunication systems	H0038	GT	HS	U5	\$15.13
15 minutes							Utilization Criteria	TBD				
Parent Peer Support (PPS) is a strength-based rehabilitative service provided to parents/caregivers that is expected to increase the youth/family's capacity to function within their home, school, and community while promoting recovery. These services are rendered by a CPS-P (Certified Peer Support – Parent) who is performing the service within the scope of their knowledge, lived experience, and education. The service exists within a system of care framework and enables timely response to the needs of all family members across several life domains, incorporating formal and informal supports, and developing realistic intervention strategies that complement the youth's natural environment. The services are geared toward promoting self-empowerment of the parent, enhancing community living skills, and developing natural supports through the following interventions:	rength-based rehabilitative service promunity while promoting recovery. Inweldege, lived experience, and eduss several life domains, incorporating moting self-empowerment of the promoting self-empowerment of the promoting self-empowerment.	I rehabilitative service portion of promoting recovery. The experience, and edual domains, incorporating empowerment of the portion.	ilitative service poting recovery. Terience, and eduins, incorporating verment of the potential of the poten	e service precovery. The sand educorporating corporating into of the precovery into free precovery.	$\sigma = \sigma$	rovided to perhese servicer cation. The servicer formal and interest incent, enhance	ve service provided to parents/caregivers that is expected to increase the youth/family's capacity to function recovery. These services are rendered by a CPS-P (Certified Peer Support – Parent) who is performing the ce, and education. The service exists within a system of care framework and enables timely response to the ncorporating formal and informal supports, and developing realistic intervention strategies that complement ent of the parent, enhancing community living skills, and developing natural supports through the following	ncrease th Peer Sup Tramework Iistic inter Iistic attr	e youth	/family' arent) varent) vables t strateg	s capacity tr who is perfo mely respoi es that com rough the fr	o function rming the nse to the plement pleming
gh positive relationships with health providers ing with identifying other community and indives, relatives, and/or religious affiliations. ing the youth and family accessing strength-bethe family to attain its vision/goals/objectives Helping the family identify natural suppo Working with families to access supports Working with the families to ensure that thereship with the multi-disciplinary team, work	ips with health providers, promotin- her community and individual supp- ligious affiliations. Illy accessing strength-based beha s vision/goals/objectives including: Ily identify natural supports that exi- ily identify natural supports which ma- milies to access supports which ma- families to ensure that they have i- disciplinary team, working with th-	th providers, promotinity and individual supplions. 3 strength-based beha slobjectives including: tural supports that exists supports which makes supports which mainsure that they have a team, working with the	iders, promoting individual supports that exipports that exipports which may ports which may that they have a working with the	dual supp dual supp used beha ncluding: 's that exi which ma ley have a	ea ii st so a	access and arts that can to ioral health, if for the familitain youth in choice in life provider compared.	, promoting access and quality services to the youth/family. idual supports that can be used by the family to achieve their goals and objectives-; these can include ased behavioral health, social services, educational services and other supports and resources required to including: including: swhich maintain youth in the least restrictive setting possible; and their IRP and resources developed. They have a choice in life aspects, sustained access to an ownership of their IRP and resources developed. In with the provider community to develop responsive and flexible resources that facilitate community-	goals and and other and ership of t	objecti suppor heir IR urces tl	ves-; th s and re and re	ese can inclesources recesources de tate commu	ude quired to veloped.
based interventions and supports that correspond with the needs of the families and their youth. Interventions are approached from a perspective of lived experience and mutuality, building family recovery, empowerment, and self-efficacy. Interventions are based upon respect and honest dialogue. The unique mutuality of the service allows the sharing of personal experience including modeling family recovery, respect, and support that is respectful of the individualized journey of a family's recovery. Equalized partnership must be established to promote shared decision making while remaining family centered. All aspects of the intervention acknowledge and honor the cultural uniqueness of each family and the many pathways to family recovery.	pports that correspond with the neer a perspective of lived experience an The unique mutuality of the service ividualized journey of a family's recontos of the intervention acknowledge	orrespond with the need of lived experience an mutuality of the service urney of a family's reconvention acknowledge	ond with the need ed experience an ity of the service of a family's recoon acknowledge	ith the neec berience an he service mily's recor cnowledge		is of the fam of mutuality, allows the st very. Equaliz and honor th	ilies and their youth. building family recovery, empowermer raring of personal experience including set partnership must be established to se cultural uniqueness of each family a	nt, and se g modelin o promote and the m	If-effice g family shared any pat	cy. Inte / recove decisio hways t	rventions ar iry, respect, n making w o family rec	e based and nile overy.
One of the primary functions of the Parent Peer Support service is to promote family/youth recovery. While the identified youth is the target for services, recovery is approached as a family journey towards self-management and developing the concept of wellness and functioning while actively managing a chronic behavioral condition, which enable the youth to be supported in wellness within his/her family unit. Families are supported in learning to live life beyond the identified behavioral health condition, focusing on identifying and enhancing the strengths of their family unit as supporters of the youth. As a part of this service intervention, a CPS-P will articulate points in their own recovery stories that are relevant to the obstacles faced by the family of consumers of behavioral health services and promote personal responsibility for family recovery as the youth/family define recovery.	Parent Peer Support service is to provards self-management and develop to be supported in wellness within his fying and enhancing the strengths of any stories that are relevant to the obstruction the year the youth/family define recovery.	Support service is to pranagement and developed in wellness within his nancing the strengths of at are relevant to the obmily define recovery.	ort service is to prent and development and developments within his the strengths of elevant to the obstine recovery.	vice is to pr nd develop is within his strengths of it to the ob ecovery.		omote family ing the concult family use their family use their family use their family is their family in their family is their family in their family is their family in the family in their family in their family in the	rvice is to promote family/youth recovery. While the identified youth is the target for services, recovery is and developing the concept of wellness and functioning while actively managing a chronic behavioral health iss within his/her family unit. Families are supported in learning to live life beyond the identified behavioral strengths of their family unit as supporters of the youth. As a part of this service intervention, a CPS-P will ant to the obstacles faced by the family of consumers of behavioral health services and promote personal recovery.	outh is thactively mactively mage to live life or this oart of this ioral healt	e targe anagin e beyor service h servi	t for ser g a chro nd the ic e interve ces and	vices, recov nic behavio entified beh ention, a CP promote pe	ery is ral health avioral S-P will rsonal
The CPS-P focuses on respectful partnerships with families, identifying the needs of the parent/caregiver and helping the parent recognize self-efficacy while building partnership between families, communities and system stakeholders in achieving the desired outcomes. This service provides the training and support necessary to promote engagement and active participation of the family in the supports/treatment/recovery planning process for the youth and assistance with the ongoing	partnerships with families, identifyin nunities and system stakeholders i articipation of the family in the supp	with families, identifyin system stakeholders i the family in the supp	milies, identifyin n stakeholders i mily in the supp	identifyin sholders i the supp	ຫ ⊑ ⊽	the needs or achieving th rts/treatment	s, identifying the needs of the parent/caregiver and helping the parent recognize self-efficacy while keholders in achieving the desired outcomes. This service provides the training and support neces in the supports/treatment/recovery planning process for the youth and assistance with the ongoing	parent re vides the t uth and a	cognize raining ssistan	self-ef and sul	ficacy while sport necessing the ongoing	building sary to

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Parent Peer Support Service - Individual

implementation and reinforcement of skills learned throughout the treatment/support process. PPS is a supportive relationship between a parent/guardian and a CPS-P hat promotes respect, trust, and warmth and empowers youth/families to make choices and decisions to enhance their family recovery.

The following are among the wide range of specific interventions and supports which are expected and allowed in the provision of this service:

- Assisting families in gaining skills to promote the families' recovery process (e.g., self-advocacy, developing natural supports, etc.);
 - Support family voice and choice by assisting the family in assuming the lead roles in all multi-disciplinary team meetings;
- Listening to the family's needs and concerns from a peer perspective, and offering suggestions for engagement in planning process; Providing ongoing emotional support, modeling and mentoring during all phases of the planning services/support planning process;

რ. 4.

- Promoting and planning for family and youth recovery, resilience and wellness;
- Working with the family to identify, articulate and build upon their strengths while addressing their concerns, needs and opportunities;
- Helping families better understand choices offered by service providers, and assisting with understanding policies, procedures, and regulations that impact the identified youth while living in the community; 6.5
- Ensuring the engagement and active participation of the family and youth in the planning process and guiding families toward taking a pro-active and selfmanaging role in their youth's treatment; ω.
- Assisting the family with the acquisition of the skills and knowledge necessary to sustain an awareness of their youth's needs as well as his/her strengths and the development and enhancement of the family's unique problem-solving skills, coping mechanisms, and strategies for the youth's illness/symptom/behavior တ်
- Assisting the parent in coordinating with other youth-serving systems, as needed, to achieve the family/youth goals; 6 7
- As needed, assisting communicating family needs to multi-disciplinary team members, while also building the family skills in self-articulating needs/desires/preferences for treatment and support with the goal of full family-guided, youth-driven self-management;
 - Supporting, modeling, and coaching families to help with their engagement in all health-related processes; 12
- Coaching parents in developing systems advocacy skills in order to take a proactive role in their youth's treatment and to obtain information and advocate with all /outh-serving systems; 13.
- Cultivating the parent/guardian's ability to make informed, independent choices including a network for information and support which will include others who have been through similar experiences; 4.
 - Building the family skills, knowledge, and tools related to the identified condition/related symptoms so that the family/youth can assume the role of self-monitoring and self-management; 15.
- Assisting the family in understanding: 9.
- Various system processes, how these relate to the youth's recovery process, and their valued role (e.g. crisis planning, IRP process);
 - What a behavioral health diagnosis means and what a journey to recovery may look like; and
- The role of services/prescribed medication in diminishing/managing the symptoms of that condition and increasing resilience and functioning in living with
- Empowering the family on behalf of the recipient; providing information regarding the nature, purpose and benefits of all services; providing interventions and support; and providing overall support and education to a caregiver to ensure that he or she is well equipped to support the youth in service transition/upon discharge and have natural supports and be able to navigate service delivery systems; 17.
- Identifying the importance of Self Care, addressing the need to maintain family whole health and wellness in order to ultimately support the youth with a behavioral health condition; ∞.
- Assisting the family in self-advocacy promoting family-guided, youth-driven services and interventions;
- Drawing upon their own experience, helping the family/youth find and maintain hope as a tool for progress towards recovery; and 20.5
- Assisting youth and families with identifying goals, representing those goals to the collaborative, multi-disciplinary treatment team, and, together, taking specific steps to achieve those goals.

Parent Peer S	Parent Peer Support Service - Individual
	 PPS is targeted to the parent/guardian of youth/young adults who meet the following criteria: a. Individual is 21 or younger; and b. Individual has a substance related condition and/or mental illness; and two or more of the following: i. Individual and his/her family needs peer-based recovery support for the acquisition of skills needed to engage in and maintain youth/family recovery;
Admission Criteria	ii. Individual and his/her family need assistance to develop self-advocacy skills to achieve self-management of the youth's behavioral health status; or iii. Individual and his/her family need assistance and support to prepare for a successful youth work/school experience; or iv. Individual and his/her family need peer modeling to increase responsibilities for youth/family recovery. 2. For the purposes of this service, "family" is defined as the person(s) who live with or provide care to the targeted youth, and may include a parent, guardians, other caregiving relatives, and foster caregivers.
Continuing Stay Criteria	 Individual continues to meet admission criteria; and Progress notes document parent/guardian progress relative to goals which the youth/family identified in the Individualized Recovery Plan, but treatment/recovery goals have not yet been achieved.
Discharge Criteria	 An adequate continuing recovery plan has been established; and one or more of the following: Goals of the Individualized Recovery Plan have been substantially met; or Individual served/family requests discharge; or Transfer to another service/level is more clinically appropriate.
Service Exclusions	 "Family" or "caregiver" does not include individuals who are employed to care for the member (excepting individuals who are identified as a foster parent). General support groups which are made available to the public to promote education and advocacy do not qualify as Parent Peer Support. If there are siblings of the targeted youth for whom a need is specified, this service is not billable unless there is applicability to the targeted youth/family. This unique billable service may not be billed for youth who resides in a congregate setting in which the caregivers are paid in a parental role (such as child caring institutions, or any other living environment that is not comprised of family, guardians, or other more permanent caregivers). A short-term exception would be if the youth were preparing for transition back to a single-family unit, the family member is present during the intervention, and the service is directed to supporting the unification of the youth and his/her identified family/caregiver and takes place in that home and community.
Clinical Exclusions	Individuals with the following conditions are excluded from admission unless there is clearly documented evidence of a behavioral health condition overlaying the diagnosis: Developmental Disability, Autism, Neurocognitive Disorder, or Traumatic Brain Injury.
	 Individuals participating in the service at any given time must have the opportunity to participate in and make decisions about the person-centered interactions offered by the Certified Peer Specialist(s). The operating agency shall have an organizational plan which articulates the following agency protocols: a. PPS cannot operate in isolation from the rest of the programs/services within the agency or affiliated organization or from other health providers. b. CPS-Ps providing this service are supported through a myriad of agency resources (e.g., Supervisors, internal agency 24/7 crisis resources, external crisis
Required Components	resources, etc.) in responding to youth/family crises. The CPS-P shall be empowered to convene multidisciplinary team meetings regarding a participating individual's needs and desires. Contact must be made with the individual receiving PPS services a minimum of twice each month. At least one of these contacts must be face-to-face and the second may be either face-to-face or telephone contact depending on the individual's support needs and documented preferences. At least 50% of PPS service units must be delivered face-to-face with the family/youth receiving the service. In the absence of the required monthly face-to-face contact have been tried and documented, the provider may bill for a maximum of two
	telephone contacts in that specified month. 6. The CPS-P must be allowed to participate as an equal practitioner partner with all staff in multidisciplinary team meetings.

Case 1:16-cv-03088-ELR Document 448-73

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Filed 11/29/23

Parent Peel	Parent Peer Support Service - Individual	
Staffing Requirements Clinical	 Services must be provided by a CPS-P; Parent Peer Support services are provided in a structured 1:1 CPS to family-served ratio; A CPS-P must receive ongoing and regular supervision by an independently licensed practitioner to include: A CPS-P must receive ongoing and regular supervision by an independently licensed practitioner to include: A CPS-P must receive ongoing and regular supervision by an independently licensed practitioner to include: A CPS-P must receive ongoing and regular supervision by an independently licensed definition and addressing implementation A CPS-P cannot provide this service to his/her own youth and/or family or to an individual with whom he/she is living; and A CPS-P cannot exceed a caseload of 30 families and shall be defined by the providing agency based upon the clinical and functional needs of the youth/families served. CPS-Ps who deliver PPS shall be involved in proactive multi-disciplinary planning to assist the youth/family in managing and/or preventing crisis situations. DPS is good privated and is provided in proactive multi-disciplinary planning and comprehensive libraries. 	Case 1:16-cv-03
Operations		088-ELR
Service Accessibility	 or this include: the use of one-to-one service intervention via Telemedicine, connecting the individual to a practitioner who speaks the individual's language versus use of interpreters; and/or the use of an interpreter via Telemedicine to support the practitioner in delivering the identified service. 	Docume
	Telemedicine may only be utilized when delivering this service to an individual for whom English is not their first language. The individual/family must consent to the use of this modality. This consent should be documented in the individual's record. The use of telemedicine should not be driven by the practitioner's/agency's convenience or preference.	ent 448-
Documentation Requirements	1. CPS-Ps must comply with all required documentation expectations set forth in this manual. 2. CPS-Ps must comply with any data collection expectations in support of the program's implementation and evaluation strategy.	73
Billing & Reporting Requirements	When Telemedicine technology is utilized for the provision of this service in accordance with the allowance in the Service Accessibility section of this definition, the code cited in the Code Detail above with the appropriate GT modifier shall be utilized in documentation and claims submission.	Filed :
Structured	Structured Residential Supports Transaction Code Detail	11/29/23

Structured	Structured Residential Supports													
Transaction Code	Code Detail	Code	Mod 1	Mod Mod Mod 2 4	Mod 3	Mod 4	Rate	Code Detail	Code	Mod 1	ModModModModRate1234	Mod 3	Mod 4	Rate
Structured Residential	Child Program	H0043	НА				As negotiated							
Unit Value	1 day							Utilization Criteria	TBD					
Service Definition	Structured Residential Supports (formerly Rehabilitation Supports for Individuals in Residential Alternatives, Levels 1 & 2) are comprehensive rehabilitative services to aid youth in developing daily living skills, interpersonal skills, and behavior management skills; and to enable youth to learn about and manage symptoms; and saistance use, and/or co-occurring disorders. This service provides support and assistance to the youth and caregivers to identify, monitor, and manage symptoms; enhance participation in group living and community activities; and, develop positive personal and interpersonal skills and behaviors to meet the youth's developmental needs as impacted by his/her behavioral health issues.	nerly Rehal ills, interpe lavior due t lanage sym	bilitation rsonal so to SED, optoms;	Suppo skills, an substar enhanc needs a	rts for Ir id beharice use e partice	ndividuk vior ma , and/or ipation cted by	als in Residential, nagement skills; co-occurring discingroup living and his/her behaviora	tion Supports for Individuals in Residential Alternatives, Levels 1 & 2) are comprehensive rehabilitative services to al skills, and behavior management skills; and to enable youth to learn about and manage symptoms; and i.D, substance use, and/or co-occurring disorders. This service provides support and assistance to the youth and ns; enhance participation in group living and community activities; and, develop positive personal and interpersona tal needs as impacted by his/her behavioral health issues.	e compre lbout and support a levelop p	hensive manage and assis ositive p	rehabil e sympt stance t	itative s oms; ar o the yc	ervices nd outh an erpers	s to d onal

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orructured	Structured Residential Supports	
	Services are delivered to youth according to their specific needs. Individual and group activities and programming must consist of services to develop skills in functional areas that interfere with the ability to live in the community, participate in educational activities; develop or maintain social relationships; or participate in social, interpersonal, recreational or community activities.	С
	Rehabilitative services must be provided in a licensed residential setting with no more than 16 individuals and must include supportive counseling, psychotherapy and adjunctive therapy supervision, and recreational, problem solving, and interpersonal skills development. Residential supports must be staffed 24 hours/day, 7 days/week.	ase 1:1
Admission Criteria	 Youth must have symptoms of a SED or a substance related disorder; and one or more of the following: Youth's symptoms/behaviors indicate a need for continuous monitoring and supervision by 24-hour staff to ensure safety; or Youth/family has insufficient or severely limited skills to maintain an adequate level of functioning, specifically identified deficits in daily living and social skills and/or community/family integration; or Youth has adaptive behaviors that significantly strain the family's or current caretaker's ability to adequately respond to the youth's needs; or 	6-cv-03088-
Continuing Stav Criteria	4. Tourn has a history of unstable housing due to a behavioral health issue of a history of unstable housing which exacerbates a behavioral health condition. Youth continues to meet Admissions Criteria.	ELR
Discharge Criteria	 Youth/family requests discharge; or Youth has acquired rehabilitative skills to independently manage his/her own housing; or Transfer to another service is warranted by change in youth's condition. 	Docui
Service Exclusions	Cannot be billed on the same day as Crisis Stabilization Unit.	ment
Clinical Exclusions	 Severity of identified youth issues precludes provision of services in this service. Youth with the following conditions are excluded from admission unless there is clearly documented evidence of psychiatric condition overlaying the diagnosis: Intellectual/Developmental Disabilities, Autism, Neurocognitive Disorder, or Traumatic Brain Injury. Youth is actively using unauthorized drugs or alcohol (which should not indicate a need for discharge, but for a review of need for more intensive services). Youth can effectively and safely be supported with a lower intensity service. 	448-73 F
Required	 The organization must have an executive director or program director charged with the responsibility for day-to-day management of the organization. If applicable, the organization must be licensed by the Georgia Department of Human Services/CCI or the Department of Community Health/HRF to provide residential services to youth with SED and/or substance use disorder diagnosis. If the agency does not have a license/letter from either the DHS/CCI or DCH/HFR related to operations, there must be enough administrative documentation to support the non-applicability of a license. The residential program must provide a structured and supported living environment 24 hours a day, 7 days a week. Structured Residential Supports must provide at least 5 hours per week of structured programming and/or services. 	Filed 11/29/23
Staffing Requirements	 Any Level 5 and higher practitioner may provide all Residential Rehabilitation Services. If applicable, facilities must comply with any staffing requirements set forth for mental health and substance abuse facilities by the Department of Community Health, Healthcare Facilities Regulation Division (see Required Components, Item 2 above). An independently licensed practitioner or SUD credentialed practitioner (MAC, CAADC, CAC-II, or GCADC-II or -III) must provide clinical supervision for Residential Support Services. This person is available for emergencies 24 hours/7 days a week. The organization that provides direct residential services must have written policies and procedures for selecting and hiring residential and clinical staff in accordance with their applicable license/accreditation/certification. The organization must have a mechanism for ongoing monitoring of staff licensure, certification, or professional registration such as an annual confirmation process concurrent with a performance evaluation that includes repeats of screening checks outlined above. 	Page 112 of 627

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		Case	1:16-cv-0	3088-	ELR	I	Docu	ıment 4	48	-73		Filed	11/	/29/	23	ı	Page	113 of	627
	The organization must have a written description of the Structured Residential Support services it offers that includes, at a minimum, the purpose of the service; the intended population to be served; treatment modalities provided by the service; level of supervision and oversight provided; and typical treatment objectives and	Structured Residential Supports assist youth in developing daily living skills that enable them to manage the symptoms and behaviors linked to their psychiatric or substance use disorder diagnosis. Services must be delivered to individuals according to their specific needs. Individual and group activities and programming consists of services geared toward developing skills in functional areas that interfere with the vouth's ability to participate in the community, retain school tenure.	develop or maintain social relationships, or age-appropriately participate in social, interpersonal, or community activities. Structured Residential Supports must include symptom management or supportive counseling; behavioral management; medication education, training and support; support, supervision, and problem-solving skill development; development of community living skills that serve to promote age-appropriate utilization of community-based services; and/or social or recreational skill training to improve communication skills, manage symptoms, and facilitate age-appropriate		The organization must develop and maintain sufficient written documentation to support the Structured Residential Support Services for which billing is made. This	documentation, at a minimum, must confirm that the Individual for whom billing is requested was a resident of the residential service on the date of service. The youth's record must also include each week's programming/service schedule in order to document the provision of the required amount of service.	Weekly progress notes must be entered in the youth's record to enable the monitoring of the youth's progress toward meeting treatment and rehabilitation goals and to reflect the Individualized Resiliency Plan implementation. Each note must be signed and dated and must include the professional designation of the individual	making the entry. Documentation must be legible and concise and include the printed name and the signature of the treating practitioner. The name, title, and credentials of the individual providing the service must reflect the staffing requirements established for the Rehabilitation Service being delivered.		cess and well-being of the residents.	,	delivered.	The organization must maintain a written evacuation plan to be used in the case of fire or other disaster. An appropriate written certificate of compliance must be obtained that all applicable fire and safety code requirements have been safisfied. Derivdic fire drills must be conducted.	מו מפ כסותתקומת.	The program must be responsible for providing physical facilities that are structurally sound and meet all applicable federal, state, and local regulations for		Span billing may occur for this service, meaning the start and end date are not the same on a given service claim line); however, spans cannot cross months (e.g. start date and end date must be within the same month).		Code Mod Mod Mod Rate
	tial Support services it offers that include ice; level of supervision and oversight p	that enable them to manage the symptors according to their specific needs. Indiviniterfere with the youth's ability to partic	develop or maintain social relationships, or age-appropriately participate in social, interpersonal, or community activities. Structured Residential Supports must include symptom management or supportive counseling; behavioral management; medication education, training support, support, supervision, and problem-solving skill development; development of community living skills that serve to promote age-appropriate utiliz community-based services; and/or social or recreational skill training to improve community-based services; and/or social or recreational skill training to improve community-based services; and/or social or recreational skill training to improve community-based services; and social or recreational skill training to improve community based services; and social or recreational skill training to improve community based services; and social or recreational skill training to improve community based services; and social or recreational skill training to improve community based services; and social or recreational skill training to improve community based services; and social or recreational skill training to improve community based services; and social or recreational skill training to improve community based services; and social or recreational skill training to improve community based services; and social or recreational skill training to improve community based services; and social or recreational skill training to improve community based services; and social or recreational skill training to improve community based services; and social or recreational skill training to improve community based services; and services are services and services and services and services are services.		on to support the Structured Residential	documentation, at a minimum, must confirm that the Individual for whom billing is requested was a resident of the residential service on the date of youth's record must also include each week's programming/service schedule in order to document the provision of the required amount of service.	monitoring of the youth's progress towalt be signed and dated and must include	making the entry. Documentation must be legible and concise and include the printed name and the signature of the treating practitioner. The nai individual providing the service must reflect the staffing requirements established for the Rehabilitation Service being delivered.	ent facilities, etc.	Structured Residential Supports may only be provided in facilities that have no more than 16 beds. Each residential facility must be arranged and maintained to provide adequate measures for the health, safety, access and well-being of the residents.		All areas of the residential facility must appear clean, safe, appropriately equipped, and fumished for the services delivered. The organization must comoly with the Americans with Disabilities Act.	The organization must maintain a written evacuation plan to be used in the case of fire or other disaster. An appropriate written centrained indication that all applicable fire and cafety code requirements have been catisfied. Deriodic fire drills must be conducted		structurally sound and meet all applicable		he same on a given service claim line); l		Code Detail
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Structured Residential Supports	 The organization must have a written description of the intended population to be served; treatment modalities perpend outcomes. 	2. Structured Residential Sup substance use disorder dia consists of services geared	develop or maintain social relationships, or age-approprial. Structured Residential Supports must include symptom support; support, supervision, and problem-solving skill community-based services; and/or social or recreational	interpersonal behavior. This is not a Medicaid-billable service.	1. The organization must deve	documentation, at a minima youth's record must also in	Weekly progress notes must to reflect the Individualized	making the entry. 3. Documentation must be legindividual providing the ser-	Applicable to traditional residential settings such as group homes, treatment facilities, etc.	 Structured Residential Supports may only be provided in facilities that have no more than 16 beds. Each residential facility must be arranged and maintained to provide adequate measures for the he 			6. The organization must ma	Evacuation routes must be clearly marked by exit signs.		adequacy of construction, safety, sanitation, and health.	Span billing may occur for this service, meaning the date and end date must be within the same month)		Substance Abuse Intensive Outpatient Program: Adolescent Transaction Code Detail Code Mod Mod Mod Mod
Structured I		Clinical	Operations	Add'l Medicaid			Documentation Requirements					Facilities	Management			Billing &	Reporting Requirements		Substance / Transaction

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ient Pr	Code	
buse Intensive Outpat	Code Detail	
Substance A	Transaction	Code

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Intensive Outpatient Program	Child Program, Practitioner Lev	Child Program, Practitioner Level 3, In-Clinic	H0015	¥ H	U3	90	26.40	Child Program, Practitioner Level 3, Out-of-Clinic	H0015 H	H H	N3	10	33.00	
	Child Program, Practitioner Lev	Child Program, Practitioner Level 4, In-Clinic	H0015	H	40	9n	17.72	Child Program, Practitioner Level 4, Out-of-Clinic	H0015 F	HA	4 7	10 10	21.64	
	Child Program, Practitioner Lev	Child Program, Practitioner Level 5, In-Clinic	H0015	¥	U5	9n	13.20	Child Program, Practitioner Level 5, Out-of-Clinic	H0015 F	HA	U5	10 10	16.12	Case
Unit Value	1 hour							Utilization Requirements	TBD					e 1
	An outp recovery	An outpatient approach to treatment services for adolescents recovery skills; including the negative impact of substances, t	tment serv	ices for	adoles	cents 13 - 17 ces, tools for	years old v developing	An outpatient approach to treatment services for adolescents 13 - 17 years old who require structure and support to achieve and sustain recovery, focusing on early recovery skills; including the negative impact of substances, tools for developing support, and relapse prevention skills.	ieve and sust	ain reo	overy,	focusing on e	arly	.:16-c
Service Definition	Through substan hours to illness a	Through the use of a multi-disciplinary team, medical, therape substance use disorders in scheduled sessions, utilizing the ihours to enable youth to maintain residence in their communi illness and response to treatment based on the individualized	ciplinary te neduled se ain resider ent based	sam, me ssions, nce in th	dical, tł utilizing ieir con ndividua	nerapeutic ar I the identifie Imunity, contalized treatm	nd recovery d componer inue work c	Through the use of a multi-disciplinary team, medical, therapeutic and recovery supports are provided in a coordinated approach to access and treat youth with substance use disorders in scheduled sessions, utilizing the identified components of the service guideline. This service can be delivered during the day or evening hours to enable youth to maintain residence in their community, continue work or thrive in school. The duration of treatment should vary with the severity of the youth's illness and response to treatment based on the individualized treatment plan, utilizing the best/evidenced based practices for the service delivery and support.	approach to are can be delive sent should varente serves	ccess a pred du ary with ice deli	and tre iring th the se ivery a	at youth with e day or even werity of the yerld support.	ng outh's	v-03088-E
	1. A [2. Yo	A DSM diagnosis of Substance Use Disorder or a Substan Youth meets the age criteria for adolescent treatment; and	stance Use eria for add	Disorc	er or a treatm	Substance Lent; and	se Disorde	A DSM diagnosis of Substance Use Disorder or a Substance Use Disorder with a co-occurring DSM diagnosis of mental illness and/or IDD; and Youth meets the age criteria for adolescent treatment; and	nental illness	and/or	IDD; a	pu		LR
		outh's biomedical conditions are stable or are being coa. The youth is currently able to maintain behavioral	tions are s	stable or mainta	are be n beha	ing concurre vioral stabilit	ntly address / for more tl	Youth's biomedical conditions are stable or are being concurrently addressed (if applicable) and one or more of the following: a. The youth is currently able to maintain behavioral stability for more than a 72-hour period, as evidenced by distractibility, negative emotions, or generalized	e following: listractibility, n	egative	e emot	ions, or gener	alized	Docu
	ο ο Ο		d of drinkii is incapad	ng or dr citating,	ug use destabi	without close lizing or cau:	monitoring sing the you	There is a likelihood of drinking or drug use without close monitoring and structured support; or The substance use is incapacitating, destabilizing or causing the youth anguish or distress and the youth demonstrates a pattern or alcohol and/or drug use	monstrates a	pattem	or alc	ohol and/or dr	esn br	ıment
Admission Criteria	-	- - =	। a significः nce use hi ∍ youth's a	ant impo istory af ibility to	airment ter pre√ mainta	of interperso ious treatme in sobriety; o	nal occupal nt indicates r	that has resulted in a significant impairment of interpersonal occupational and/or educational; or The youth's substance use history after previous treatment indicates that provision of outpatient services alone (without an organized program model) is not likely to result in the youth's ability to maintain sobriety; or	ne (without ar	า organ	iized p	rogram model) is not	448-7
	φ. ∸.		ble expect sed as nee	ation the	at the y	outh can imposel 2 or 3.1;	rove demoi	lhere is a reasonable expectation that the youth can improve demonstrably within 3-6 months; or The youth is assessed as needing ASAM Level 2 or 3.1; or						3
	တ်	, ,	ignificant (cognitiv partici	e and/o	r intellectual	impairment	The youth has no significant cognitive and/or intellectual impairments that will prevent participation in and benefit from the services offered and has sufficient cognitive capacity to participate in and benefit from the services offered or	nefit from the	service	es offe	ed and has		Filed
	<u>-</u>		tively suici	idal or h	omicid	al, and the yc	outh's crisis,	The youth is not actively suicidal or homicidal, and the youth's crisis, and/or inpatient needs (if any) have been met prior to participation in the program.	en met prior to	partic	ipation	in the prograi	<u> </u>	11/2
	c 다 급	The youth's condition continues to meet the admission criteria; or	tinues to	meet th	e admis	sion criteria;	or	Operation of the state of the s	20.000	-	; ;	og legeitenen		29/2
		riogress notes accurrent progress in reducing use of sand interpersonal skills; understanding substance use d	ir progress inderstand	in reuc Jing sub	stance	use disorder	ວຣ, uevelo _l s; and/or es	ringless notes document progress in reducing use of substances, developing social retworks and mestyre changes, increasing educational, vocational, social and interpersonal skills, understanding substance use disorders; and/or establishing a commitment to a recovery and maintenance program, but the overall goals	ss, illicreasiiry and maintenar	euuca Ice pro	gram,	vocational, so but the overal	goals	3
Continuing Stay Criteria	0 1	of the recovery plan have not been met; or There is a reasonable expectation that the	not been pectation t	met; or that the	vouth c	an achieve tl	ne goals in	of the recovery plan have not been met; or There is a reasonable expectation that the vouth can achieve the goals in the necessary reauthorization time frame; or	e: or					Pag
	4.	ne youth recognizes and	d understa	ands rela	apse tri	gers, but he	s not devel	The youth recognizes and understands relapse triggers, but has not developed sufficient coping skills to interrupt or postpone gratification or to change related	or postpone gr	ratificat	ion or	to change rela		ge 1
	5. Yo	madequate impuise control benaviors, or Youth's substance seeking behaviors, wh	אשוושט וטו ng behavio	ors, or ors, whil	e dimin	shing, have	not been re	madequate impuise control benaviors, or Youth's substance seeking behaviors, while diminishing, have not been reduced sufficiently to support function outside of a structure treatment environment.	tside of a stru	cture tr	eatme	nt environmer		.14
Discharge Criteria	1. An	an adequate continuing care or discharge plan is established, and a. Goals of the treatment plan have been substantially met; or	care or dis ent plan h	charge ave be	plan is	established, antially met;	and linkage or	An adequate continuing care or discharge plan is established, and linkages are in place, and one or more of the following: a. Goals of the treatment plan have been substantially met; or	following:					of 62 ⁻
	ρ.	 Youth's problems have diminished in such a way 	ave dimin	Ished Ir	such a		y can be m	that they can be managed through less intensive services; or	or					7

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	c. Youth recognizes severity of his/her drug/alcohol usage and is beginning to apply skills necessary to maintain recovery by accessing appropriate
	2. Transfer to a higher level of service is warranted by the following: a. Change in the vouth's condition or nonparticipation: or
	Youth exhibits symptoms of acute intoxica
	e. Touit has consistently railed to achieve essential recovery objectives despite revisions to the individualized treathent pian and advice concerning the
	f. Youth continues alcohol/drug use to such an extent that no further process is likely to occur.
	1. Service elements included within SAIOP include counseling, group outpatient services, family outpatient services, and community support. Therefore, it is
Sprivice	expected that these services are not generally ordered/authorized/provided outside of SAIOP. Any exception must be clinically justified in the medical record and
Exclusions	may be subject to scrutiny by the ASO. Exceptions in offering these services external to SAIOP include scenarios where there are sensitive and targeted clinical
	issues to be addressed triat require a specialized intervention or privacy (e.g., sexual addse, criminal justice system involvement, etc.). virien an exception is clinically institled, services must not duplicate interventions provided by SAIOP
Clinical	2. Youth with any of the following unless there is clearly documented evidence of a Substance Use Disorder: Autism, Developmental Disabilities, Neurocognitive
EXCIDSIONS	Disorder, Traumatic Brain Injury.
	1. This service must be licensed by DCH/HFR under the Rules and Regulations for Drug Abuse Treatment Programs, 290-4-2.
	•
	times of day for certain activities.
	3. These services should be scheduled and available at least 3 hours per day, 4 days per week (12 hrs. /week), with no more than 2 consecutive days without service
	4. The program utilizes methods, materials, settings, and outside resources appropriate to the developmental and cognitive levels, capabilities, age, gender, and
	5. The program utilizes methods, materials, approaches, activities, settings, and outside resources appropriate for and targeted to youths with co-occurring disorders
	of mental illness and substance use and targeted to youths with co-occurring developmental disabilities and substance use when such youths are referred to the
	program. C. The angular ingle with the family to develor angular and flexible account and that familiate community beard interventions and a manual that
Required	o. The program win work with the families and their vorith
Components	_
	8. The program is provided over a period of several weeks or months and often follows withdrawal management or residential services and should be evident in the
	9. This service must operate at an established site approved to bill Medicaid for services. However, limited individual or group activities may take place off-site in
	natural community settings as is appropriate to each youth's treatment plan. (Narcotics Anonymous (NA) and/or Alcoholics Anonymous (AA) meetings offsite may
	be considered part of these limited individual or group activities for billing purposes only when time limited and only when the purpose of the activity is introduction
	of the participating youth to available NA and/or AA services, groups or sponsors. NA and AA meetings occurring during the SA Intensive Outpatient package may
	not be counted as billable hours for any individual outpatient services, nor may billing related to these meetings be counted beyond the basic introduction of a
	youth to the NA/AA experience.).
	10. This service may operate in the same building as other services; however, there must be a distinct separation between services in staffing, program description,
	and physical space during the hours the SA Intensive Outpatient Services is in operation.

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- The maximum number of units that can be billed a day for SAIOP is 5 units.
 There are some outpatient services which are required components of SAIOP but because o
- There are some outpatient services which are required components of SAIOP but because of their frequency of use, are not practical as part of the bundled services. The following are those additional services that are to be billed unbundled as part of the SAIOP program:

Service	Maximum Authorization	Maximum Authorization Daily Maximum Billable Units
Behavioral Health Assessment & Service Plan Development 33	32	24
Diagnostic Assessment	4	2
Psychiatric Treatment	12	1
Nursing Assessment and Care	48	16
Interactive Complexity (as a modifier to Psychiatric Treatment, Diagnostic Assessment, Individual Counseling, and Group Counseling)	48	4
Community Transition Planning	50	12

- The following services are included in the SAIOP and should not be requested as part of the SAIOP authorization, nor should they be ordered separately outside of the SAIOP authorization except under special circumstances (see Service Exclusions section):
 - a. Family Outpatient Services (Counseling & Training)

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Billing & Reporting Requirements

- b. Group Outpatient Services (Counseling & Training)
 - Individual Counseling
- d. Community Support
- Rounding is applied to the person's cumulative hours/day at the Substance Abuse Intensive Outpatient Program (excluding non-programmatic time). The provider shall follow the guidance in the rounding policy included in this Provider Manual, and, specific to this service, the person served must have participated in at least 50% of the hour in order to bill for one unit of this service. For instance, if an individual participates in the program from 9:00 am -1:15 pm excluding a 30-minute break for lunch, his/her participating hours are 3.75 hours. The rounding policy is applied to the .75 hour and the units billed for that day are 4 units. Practitioner ype must still be addressed and so those 4 units must be adequately assigned to either a U3, U4 or U5 practitioner type as reflected in the log for that day's 4.
- Approved providers of this service may submit claims/encounters for the unbundled services listed in the table above, up to the daily maximum amount for each service. Program expectations are that these complementary services follow the content of this Service Guideline as well as the clearly defined service group 5
- Services authorized via the SAIOP Type of Care are only billable during the designated programmatic hours. If an individual needs additional service time outside the designated programmatic hours or needs services other than the designated programmatic services, AND the provider is enrolled to provide those services, the services are to be separately ordered and authorized (for example, services through the Non-Intensive Outpatient Type of Care) .

Youth Peer	fouth Peer Support - Group												
Transaction	Code Detail	Code	Mod	Mod Mod Mod	Mod	Mod	Rate	Code Detail	Code	Mod	Mod	Mod Mod Mod Mod	Mod
Code			1	2	3	4				1	2	3	4
Peer Support	Practitioner Level 4, In-Clinic	H0038	HA	Й	U4	90	\$17.72	Practitioner Level 4, Out-of-Clinic	8E00H	HA	Р	U4	L 2
Services	Practitioner Level 5, In-Clinic	H0038	HA	Р Р	N2	90	\$13.20	Practitioner Level 5, Out-of-Clinic	8E00H	HA	穷	O.S	L 1

\$21.64

Rate

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Youth Peer	Youth Peer Support - Group	
Unit Value	1 hour TBD TBD	
	Youth Peer Support (YPS-G) is a strength-based rehabilitative service provided to youth/young adults that is expected to increase the youth/family's capacity to function within their home, school, and community while promoting recovery. These services are rendered by a CPS-Y (Certified Peer Support – Youth) who is performing the service within the scope of their knowledge, lived-experience, and education. The service exists within a system of care framework and enables timely response to the needs of the youth and all family members across several life domains, incorporating formal and informal supports, and developing realistic intervention strategies that complement the youth/family natural environment.	Case 1:
	The services are geared toward promoting self-empowerment of the youth, enhancing community living skills, and developing natural supports through the following interventions:	16-c\
	 a. Through positive relationships with health providers, promoting access and quality services to the youth/young adults and family. b. Assisting with identifying other community and individual supports that can be used by the youth/young adult to achieve their goals and objectives; these can include friends, relatives, and/or religious affiliations. c. Assisting the youth/young adult and family accessing strength-based behavioral health, social services, educational services and other supports and resources required to assist the family to attain its vision/goals/objectives including: 	v-03088-ELF
	 i. Helping the youth/young adult identify natural supports that exist for the family; and ii. Working with youth/young adults to access supports which maintain youth in the least restrictive setting possible; and iii. Working with the youth to ensure that they have a choice in life aspects, sustained access to an ownership of their IRP and resources developed. d. In partnership with the multi-disciplinary team, working with the provider community to develop responsive and flexible resources that facilitate community-based interventions and supports that correspond with the needs of the youth/young adult and their family. 	R Docume
Service Definition	Interventions are approached from a perspective of lived experience and mutuality, building youth recovery, empowerment, and self-efficacy. Interventions are based upon respect and honest dialogue. The unique mutuality of the service allows the sharing of personal experience including modeling youth recovery, respect, and support that is respectful of the individualized journey of a family's recovery. Equalized partnership must be established to promote shared decision making while remaining family centered. All aspects of the intervention acknowledge and honor the cultural uniqueness of each family and the many pathways to family recovery.	ent 448-73
	One of the primary functions of the Youth Peer Support service is to promote family/youth recovery. While the identified youth is the target for services, recovery is approached as a family journey towards self-management and developing the concept of wellness and functioning while actively managing a chronic behavioral health condition, which enable the youth to be supported in wellness within his/her family unit. Youth are supported by the CPS-Y and by participating group members in learning to live life beyond the identified behavioral health condition, focusing on identifying and enhancing their individual strengths as well as the strengths of their family unit as supporters of the youth. As a part of this service intervention, a CPS-Y will articulate points in their own recovery stories that are relevant to the obstacles faced by the youth/young adult of consumers of behavioral health services and promote personal responsibility for individual recovery as the youth/family define recovery.	Filed 11/29/23
	The group focuses on building respectful partnerships with youth/young adult members, identifying the needs, and helping the youth/young adult recognize self-efficacy while building partnership between families, communities and system stakeholders in achieving the desired outcomes. This service provides the training and support necessary to promote engagement and active participation of the youth/young adult in the supports/treatment/recovery planning process for the youth and assistance with the ongoing implementation and reinforcement of skills learned throughout the treatment/support process. YPS is a supportive relationship between a youth/young adult and a CPS-Y that promotes respect, trust, and warmth and empowers the group participants to make choices and decisions to enhance their family recovery.	Page 119 of
	The following are among the wide range of specific interventions and supports which are expected and allowed in the provision of this service: a. Facilitating peer support in and among the participating group youth/young adult members;	627

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	Case	1:16-	cv-030)88-EI	_R	Docu	ment	448-	73	Filed	11/2	9/23	Pa	age 1	L20	of 627	7
Youth Peer Support - Group b. Assisting youth/young adults in gaining skills to promote their recovery process (e.g., self-advocacy, developing natural supports, etc.); c. Support youth/young adult voice and choice by assisting the family in assuming the lead roles in all multi-disciplinary team meetings; d. Listening to the youth/young adults needs and concerns from a peer perspective, and offering suggestions for engagement in planning process;	Providing ongoing emotional support, modeling Promoting and planning for family and youth re Working with the youth/young adult to identify,			and the development and enhancement of the family's unique problem-solving skills, coping mechanisms, and strategies for the youth's illness/symptom/behavior management: k Assisting the youth/young adult and family participants in coordinating with other youth-serving systems, as needed to achieve the youth/family goals:		m. Supporting, modeling, and coaching youth/young adult to help with their engagement in all health-related processes; n. Coaching youth/young adults in developing systems advocacy skills in order to take a proactive role in their treatment and to obtain information and advocate	with all youth-serving systems, o. Cultivating the youth/young adult ability to make informed, independent choices including a network for information and support which will include others who have been through similar experiences:	p. Building the youth/young adult skills, knowledge, and tools related to the identified condition/related symptoms so that the youth/family can assume the role of self-monitoring and self-management; and	 Assisting the youth/young adult participants in understanding: Various system processes, how these relate to the youth's recovery process, and their valued role (e.g. crisis planning, IRP process); 	ii. What a behavioral health diagnosis means and what a journey to recovery may look like; iii. The role of services/prescribed medication in diminishing/managing the symptoms of that condition and increasing resilience and functioning in living	r. Empowering the youth/young adult and family on behalf of the recipient; providing information regarding the nature, purpose and benefits of all services; providing interventions and support; and providing overall support and education to the youth/young adult and family to ensure that they are well equipped to	support the youth in service transition/upon discharge and have natural supports and be able to navigate service delivery systems; s. Identifying the importance of Self Care, addressing the need to maintain family whole health and wellness in order to ultimately support the youth with a	benavioral health condition; t. Assisting the participants in self-advocacy promoting family-guided, youth-driven services and interventions;	u. Drawing upon their own experience, helping the youth/family find and maintain hope as a tool for progress towards recovery; and vote the collaborative, multi-disciplinary treatment team, and, together, taking	specific steps to achieve those goals.	1. YPS is targeted to the youth/young adults who meet the following criteria: a. Individual is 20 or younger; and b. Individual has a substance related condition/challenge and/or mental illness; and two or more of the following :	i. Individual and his/her family needs peer-based recovery support for the acquisition of skills needed to engage in and maintain youth/family recovery; or
Youth P																Admission Criteria	

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upport	Youth Peer Support - Group ii. Individual and his/her family need assistance to develop self-advocacy skills to achieve self-management of the youth's behavioral health status; or iii. Individual and his/her family need assistance and support to prepare for a successful youth work/school experience; or	
2. For the pu caregiving	For the purposes of this service, "family" is defined as the person(s) who live with or provide care to the targeted youth, and may include a parent, guardians, other caregiving relatives, and foster caregivers.	Cas
 Individua Progress goals ha 	Individual continues to meet admission criteria; and Progress notes document parent/guardian progress relative to goals which the youth/family identified in the Individualized Recovery Plan, but treatment/recovery goals have not yet been achieved.	se 1:16-0
1. An adec a. b. c.	An adequate continuing recovery plan has been established; and one or more of the following: a. Goals of the Individualized Recovery Plan have been substantially met; or b. Individual served/family requests discharge; or c. Transfer to another service/level is more clinically appropriate.	cv-03088-
 "Famil This u institution 	"Family" or "caregiver" does not include individuals who are employed to care for the member (excepting individuals who are identified as a foster parent). This unique billable service may not be billed for youth who resides in a congregate setting in which the caregivers are paid in a parental role (such as child caring institutions, or any other living environment that is not comprised of family, guardians, or other more permanent caregivers). A short-term exception would be if the	ELR
youth unifica 3. Gener 4. If ther	youth were preparing for transition back to a single-family unit, the family member is present during the intervention, and the service is directed to supporting the unification/reunification of the youth and his/her identified family/caregiver and takes place in that home and community. General support groups which are made available to the public to promote education and advocacy do not qualify as Parent Peer Support. If there are siblings of the targeted youth for whom a need is specified, this service is not billable unless there is applicability to the targeted youth for whom a need is specified, this service is not billable unless there is applicability to the targeted youth for whom a need is specified, this service is not billable unless there is applicability to the targeted youth for whom a need is specified, this service is not billable unless there is applicability to the targeted youth for whom a need is specified.	Docume
ndividual liagnosis	Individuals with the following conditions are excluded from admission unless there is clearly documented evidence of a behavioral health condition overlaying the diagnosis: Developmental Disability, Autism, Neurocognitive Disorder, or Traumatic Brain Injury.	nt 44
1. Individue offere 2. The c	Individuals participating in the service at any given time must have the opportunity to participate in and make decisions about the person-centered interactions offered by the Certified Peer Specialist(s), while also respecting the group dynamics. The operating agency shall have an organizational plan which articulates the following agency protocols:	8-73
	a. YPS cannot operate in isolation from the rest of the programs/services within the agency or affiliated organization or from other health providers; b. CPS-Ys providing this service are supported through a myriad of agency resources (e.g. Supervisors, internal agency 24/7 crisis resources, external	Filed
3. The		11/29
	The CPS-Y must be allowed to participate as an equal practitioner partner with all staff in multidisciplinary team meetings.	9/23
1. Direc 2. Yout 3. A CF	Servee Pee	3 Paç
	 Supervisor's availability to provide backup, support, and/or consultation to the CPS-Y as needed; The partnership between the Supervisor and CPS-Y in collaboratively assessing fidelity to the service definition and addressing implementation 	ge 12
4. Wher	successes/chairenges, When a CPS-P is also providing a service to the parents/guardians of the youth/young adult, these identified CPSs shall coordinate to reinforce various aspects of the youth's IRP.	1 of 6
5. A CP	A CPS-Y cannot provide this service to his/her own youth and/or family or to an individual with whom he/she is living.	27

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Youth Peer	Youth Peer Support - Group	
Clinical	1. CPS-Ys who deliver YPS shall be involved in proactive multi-disciplinary planning to assist the youth/family in managing and/or preventing crisis situations;	
Operations	2. YPS is goal-oriented and is provided in accordance with the youth's collaborative and comprehensive IRP.	
Service	1. YPS may be provided at a service site, in the recipient's home, or in any community setting appropriate for providing the services as specified in the recipient's	
Accessibility	behavioral health recovery plan; via telephone (although 50% must be provided face to face, telephonic contacts are limited to 50%).	
Documentation 1	1. CPS-Ys must comply with all required documentation expectations set forth in this manual.	
Requirements	2. CPS-Ys must comply with any data collection expectations in support of the program's implementation and evaluation strategy.	

Youth Peer	Youth Peer Support - Individual													
Transaction Code	Code Detail	Code	Mod 1	Mod 2	Mod 3	Mod 4	Rate	Code Detail	Code	Mod 1	Mod 2	Mod M	Mod Rate 4	te
	Practitioner Level 4, In-Clinic	H0038	НА	104	9N		20.30	Practitioner Level 4, Out-of-Clinic	H0038	НА	N4	10	24.36	36
Peer Supports	Practitioner Level 5, In-Clinic	H0038	HA	US	90		15.13	Practitioner Level 5, Out-of-Clinic	H0038	НА	U5	U7	18.15	15
	Practitioner Level 4, Via interactive audio and video telecommunication systems	H0038	GT	НА	U4		20.30	Practitioner Level 5, Via interactive audio and video telecommunication systems	H0038	GT	HA	US	15.13	13
Unit Value	15 minutes							Utilization Criteria	TBD					
	Youth Peer Support-Individual (YPS-I) is a strength-based rehabilitative service provided to youth who are living with a mental health, substance use and/or co-occurring health condition. The one-to-one service rendered by a CPS-Y (Certified Peer Support – Youth) practitioner models recovery by using lived experience as a tool for the service intervention within the scope of their knowledge, skills and education. This service intervention is expected to increase the targeted youth's' capacity to function and thrive within their home, school, and communities of choice. The service exists within a full family-guided, youth-driven system of care framework and enables response to the needs of the youth across several life domains, incorporating formal and informal supports, and developing realistic intervention strategies that complement the youth's natural resources and environment.	3-1) is a stranding and compared soft some some across services and compared some some some some some some some some	ength-tered by cowled munities veral life to anviro	ased na CPS ge, skil s of chc	ehabilititery (Cerls and € Is and I	ative se rtified F education of servi	ervice proves on This seconds. This seconds on This second on This s	sed rehabilitative service provided to youth who are living with a mental health, substance use and/or co-occurrin CPS-Y (Certified Peer Support – Youth) practitioner models recovery by using lived experience as a tool for the s, skills and education. This service intervention is expected to increase the targeted youth's' capacity to function of choice. The service exists within a full family-guided, youth-driven system of care framework and enables domains, incorporating formal and informal supports, and developing realistic intervention strategies that ment.	mental hea overy by us crease the ven system ping realisti	Ith, subsing liverangeline liverangeline targetection of care contents.	stance u d experi d youth's framew ention st	se and/or cence as a tence and en cork and en crategies the	co-occurri ool for the to function ables at	u u
	The services are geared toward promoting self-empowerment of the youth, enhancing community living skills, and developing/enhancing natural supports. The following are among the wide - range of specific interventions and supports which are expected and allowed in the provision of this service:	moting se ific interve	If-empo	werme and sup	nt of the	e youth which a	ı, enhancir re expecte	ig community living skills, and deve d and allowed in the provision of thi	loping/enh is service:	ancing r	natural s	upports. Tl	ne followi	
Service Definition	 Promoting a service culture of respect, wellness, dignity, and individuals who can achieve full, rich lives on their own terms; Facilitating the process for the youth in his/her exploration of second and second accounts. 	e of respe ve full, rich the youth	ct, welli lives o in his/r	ness, d n their ter exp	ignity, a own ter oration	and strems; of stre	ength, by c	Promoting a service culture of respect, wellness, dignity, and strength, by changing the labels which have emerged in the system and seeing young persons as individuals who can achieve full, rich lives on their own terms; Facilitating the process for the youth in his/her exploration of strengths and supports of wellness/resiliency/recovery and ultimately supporting the youth/family	overy and	system	n and se ly suppo	eing young	persons outh/famil	as >
	voice and choice in such activities as self-adv for his/her own health/wellness/recovery, etc.	activities a ness/reco	s self-au very, et	dvocati.	ng for n	J/spaaı	references	voice and choice in such activities as self-advocating for needs/preferences, assuming the lead roles in multi-disciplinary team meetings, holding accountability for his/her own health/wellness/recovery, etc.;	disciplinary	team m	eetings	holding ac	countabil	, <u>æ</u>
	3. Drawing upon their own experience, helping the family/youth find and maintain hope as a tool for p 4. Assisting the youth in identifying the tools of wellness/resiliency/recovery available in everyday life; 5. Crosting the propertientities and dialogues to explore behavioral health, what wellness is for the con-	xperience, tifying the	helping tools of	the far wellne	mily/you ss/resil	uth finc liency/r ioral bo	l and main: ecovery av	Drawing upon their own experience, helping the family/youth find and maintain hope as a tool for progress towards recovery; Assisting the youth in identifying the tools of wellness/resiliency/recovery available in everyday life; Crosting the paracturation and dialogues to explore behavioral boath, what wellness is for the specific youth and his/hor family so that the individual can	ards recov	ery;	‡ † ¢	7.00.00	200	
	define and articulate wellness and create plan	ess and c	gues to reate pla	ans wh	ich stre	ingthen	their reco	you're benavioral neam, wha welliness is for the specific you'ri a is which strengthen their recovery and resilience;		allilly,	חומו וו		2	
	Listening to the youth and family's needs and and self-direction process;	family's n	eeds ar		erns fro	om a pe	eer perspe	concerns from a peer perspective, and offering suggestions and alternatives for youth engagement in planning	altemative	s for yo	uth eng	agement in	planning	

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Youth Peer Support - Individual

- Assisting the youth and family with the acquisition of the skills and knowledge necessary to sustain an awareness of their youth's needs as well as his/her strengths and the development and enhancement of the family's unique problem-solving skills, coping mechanisms, and strategies for the youth's illness/symptom/behavior management; and relapse prevention;
- Building the youth and family skills, knowledge, and tools related to the identified condition/related symptoms/triggers so that the family/youth can assume the role of self-monitoring and self-management; œ.
 - Through positive collaboration and relationships, promoting access and quality services for the youth/family by assisting with accessing strength-based behavioral health/health services, social services, educational services and other supports and resources required to assist the family unit to attain its vision/goals/objectives including: ത്
- Creating early access to the messages of recovery and wellness;
- Helping the family identify natural supports that exist for the youth;

ъ.

- Working with youth/young adults to access supports which maintain youth in the least restrictive setting possible; ပ ၂
- Working with the youth/young adult to ensure that they have choices in life aspects, sustained access to an ownership of their IRP and resources developed;
- Working with youth/young adult to provide adequate information to make healthier choices about their use of alcohol and/or other drugs; ė.
 - Working with the provider community and other practitioners, the CPS-Y promotes the youth to self-advocate to:
 - Develop responsive and flexible resources that facilitate community-based interventions;
- Create a person-centered, recovery-oriented system of care plan that correspond with the needs of the youth/family;
- Acknowledge the importance of Self Care, addressing the need to maintain whole health and wellness. This should include support in building "recovery capital" (formal and informal community supports);
- Assisting with identifying community and individual supports (including friends, relatives, schools, religious affiliations, etc.) that can be used by the youth to achieve his/her goals and objectives; Ö
 - Assisting the youth and family participants as needed in coordinating with other youth-serving systems (or at a certain age, collaboration and engagement with adult-serving systems) to achieve the family/youth goals; ٦.
- Provide resources and educational materials to help assist youth with understanding services, options, and treatment expectations, as well assistance with developing wellness tools and coping skills, including: 9.
- Understanding various system processes, how these relate to the youth's recovery process, and their valued role (e.g. crisis planning, IRP process);
 - Understanding what a behavioral health diagnosis means and what a journey to recovery may look like; ن <u>ن</u>
- The role of services/prescribed medication in diminishing/managing the symptoms of that condition and increasing resilience and functioning in living with that condition;
- 11. Facilitating and creating advocacy, balance, and cohesion on the IRP support team between the youth/family served, professionals (including CPS-Ps who may be supporting the family), and other supporting partners.

individual/family recovery, respect, and support that is respectful of the individualized journey of a youth's/family's recovery. Equalized partnership must be established to promote shared decision making while remaining youth-driven, family-centered. All aspects of the intervention acknowledge and honor the cultural uniqueness of Interventions are approached from a perspective of lived experience and mutuality, building the youth's and family's recovery, empowerment, and self-efficacy Interventions are based upon respect and honest dialogue. The unique mutuality of the service allows the sharing of personal experience including modeling each youth and family and the many pathways to recovery.

One of the primary functions of the Youth Peer Support service is to promote youth and family recovery. While the identified youth is the target for services, recovery is chronic mental health condition, which enable the youth to be supported in wellness within his/her family unit. Youth are supported by the CPS-Y in learning to live life approached as a family journey towards self-management and developing the concept of wellness and functioning while actively managing a substance use and/or

Case 1:16-cv	03088-ELR D	ocument 448-73	3 Filed 11/29/23	Page 124 of 627
Youth Peer Support - Individual beyond the identified behavioral health condition, focusing on identifying and enhancing the strengths of the youth and the family unit. As a part of this service intervention, a CPS-Y will articulate points in their own recovery stories that are relevant to overcoming obstacles faced by the youth-recipient of behavioral health services and promote personal responsibility for recovery as the youth/family define recovery. The CPS-Y focuses on building respectful partnerships with families, identifying the needs of the youth and helping the youth recognize self-efficacy while strengthening good communication within the families and good partnerships with communities and system stakeholders in achieving the desired outcomes. This service provides the training and support necessary to promote engagement and active participation of the youth in the supports/treatment/recovery planning process for the youth and assistance with the ongoing implementation and reinforcement of skills leamed throughout the treatment/support process. YPS-I provides interventions which promote supportive relationships between a youth and a CPS-Y that promotes respect, trust, and warmth and empowers the youth to make choices and decisions to enhance	YPS-I is targeted to a youth who meets the following criteria: YPS-I is targeted to a youth who meets the following criteria: 1. Individual is age 20 or younger; and 2. Individual has a substance related condition and/or mental illness; and two or more of the following: a. Individual and his/her family needs peer-based recovery support for the acquisition of skills needed to engage in and maintain youth/family recovery; or b. Individual and his/her family need assistance and support to prepare for a successful youth work/school experience; or c. Individual and his/her family need assistance and support to prepare for a successful youth work/school experience; or	Individual continues to meet admission criteria; and 2. Progress notes document youth progress relative to goayet been achieved. An adequate continuing recovery plan has been establishe 1. Goals of the Individualized Recovery Plan have been su 2. Individual served/family requests discharge; or	Nor Individuals diag	t. 9.6. 4.
Youth	Admission Criteria	Continuing Stay Criteria Discharge	Service Exclusions Clinical Exclusions Required Components	Staffing Requirements

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Youth Peer	Youth Peer Support - Individual	
Clinical Operations	1. The youth is the primary recipient of the Youth Peer Support; however, there is an expectation that the CPS-Y is working as an integral member of the supporting team, specifically supporting the youth in articulating his/her own recovery goals and objectives, working closely with the CPS-P who is identified as a supporter to the youth's family, etc.	
	 YPS may be provided at a service site, in the recipient's home, or in any community setting appropriate for providing the services as specified in the recipient's behavioral health recovery plan; via phone (although 50% must be provided face to face, telephonic contacts are limited to 50%). To promote access, providers may use Telemedicine as a tool to provide direct interventions to individuals for whom English is not their first language. Examples of this include: 	Case 1:
Service Accessibility	 the use of one-to-one service intervention via Telemedicine, connecting the individual to a practitioner who speaks the individual's language versus use of interpreters; and/or the use of an interpreter via Telemedicine to support the practitioner in delivering the identified service. 	16-cv-03
	Telemedicine may only be utilized when delivering this service to an individual for whom English is not their first language. The individual/family must consent to the use of this modality. This consent should be documented in the individual's record. The use of telemedicine should not be driven by the practitioner's/agency's convenience or preference.	088-EL
Documentation Requirements	 CPS-Ys must comply with all required documentation expectations set forth in this manual. CPS-Ys must comply with any data collection expectations in support of the program's implementation and evaluation strategy. 	R I
Billing & Reporting Requirements	When Telemedicine technology is utilized for the provision of this service in accordance with the allowance in the Service Accessibility section of this definition, the code cited in the Code Detail above with the appropriate GT modifier shall be utilized in documentation and claims submission.	Docum
ADULT NO	ADULT NON-INTENSIVE OUTPATIENT SERVICES	ent 448-73

ADULT NON-INTENSIVE OUTPATIENT SERVICES

Addictive Di	Addictive Diseases Support Services	Si												
Transaction Code	Code Detail	Code	Mod 1	Mod 2	Mod 3	Mod 4	Rate	Code Detail	Code	Mod 1	Mod Mod 2 3	Mod 3	Mod 4	Rate
	Practitioner Level 4, In-Clinic	H2015	生	4 1	90		\$20.30	Practitioner Level 4, Out-of-Clinic	H2015	Ή	V4	U2		\$24.36
():	Practitioner Level 5, In-Clinic	H2015	生	O5	90		\$15.13	Practitioner Level 5, Out-of-Clinic	H2015	HF	O.S	U2		\$18.15
Addictive	Practitioner Level 4, In-Clinic	H2015	生	Y	U4	90	\$20.30	Practitioner Level 4, Out-of-Clinic	H2015	H	NK	U4	U2	\$24.36
Support	Practitioner Level 5, In-Clinic	H2015	生	NK	U5	90	\$15.13	Practitioner Level 5, Out-of-Clinic	H2015	HF	UK	U5	U2	\$18.15
Services	Practitioner Level 4, Via							Practitioner Level 5, Via						
	interactive audio and video	H2015	GT	生	4	90	\$20.30	interactive audio and video	H2015	GT	生	O5	90	\$15.13
	telecommunication systems							telecommunication systems						
Unit Value	15 minutes							Utilization Criteria	TBD					
	Specific to adults with substance	use disord	ers, Ad	dictive	Diseas	es Sup	port Servic	Specific to adults with substance use disorders, Addictive Diseases Support Services (ADSS) consist of individualized 1:1 substance use recovery services and	1:1 substa	nce us	e recove	ery serv	ices an	q
	supports which build on the stree	ngths and re	esilienc	e of the	indivic	dual an	d are neces	supports which build on the strengths and resilience of the individual and are necessary to assist the person in achieving recovery and wellness goals as identified in	ng recover	y and w	/ellness	goals a	s identi	fied in
Definition	the Individualized Recovery Plan. The service activities include:	The service	se activ	ities in	clude:									
	1. Assistance to the person an	d other ider	riffed r	ecover	/ partne	ers in th	ne facilitatio	Assistance to the person and other identified recovery partners in the facilitation and coordination of the Individual Recovery Plan (IRP) including the use of	Recovery	Plan (II	RP) incl	uding th	e use c	<u></u>
	motivational interviewing an	d other skill	ddns s	ort to p	omote	the pe	rson's self-a	motivational interviewing and other skills support to promote the person's self-articulation of personal goals and objectives;	jectives;					

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Required Components	 The agency providing this service must be a Tier 1 or Tier 2 provider, an Intensive Outpatient Program (IOP) specialty provider, or a WTRS provider. Contact must be made with the individual receiving ADSS services a minimum of twice each month. At least one of these contacts must be face-to-face and the second may be either face-to-face or telephone contact depending on the individual's support needs and documented preferences. At least 50% of ADSS service units must be delivered face-to-face with the identified individual receiving the service. In the absence of the required monthly face- to-face contact and if at least two unsuccessful attempts to make face-to-face contact have been tried and documented, the provider may bill for a maximum of two telephone contacts in that specified month. 	Cas
Staffing Requirements	div	e 1:10
Clinical	 ADSS may include (with the written permission of the adult individual) coordination with family and significant others and with other systems/supports (e.g., work, religious entities, corrections, aging agencies, etc.) when appropriate for treatment and recovery needs. Any necessary monitoring and follow-up to determine if the services and resources accessed have adequately met the person's needs in achieving and sustaining recovery are allowable. Coordination is an essential component of ADSS when directly related to the support and enhancement of the person's recovery. The organization must have an ADSS Organizational Plan that addresses the following; a. Description of the particular rehabilitation, recovery and natural support development models utilized, types of intervention practiced, and typical daily schedule for staff. b. Description of the staffing pattern and how staff are deployed to assure that the required staff-to-individual ratios are maintained including how unplanned 	6-cv-03088-ELR
	staff absences, illnesses, or emergencies are ac Description of the hours of operations as related Description of how the plan for services is modi- zation (frequency and intensity) of ADSS should be cal/functional needs are great, there should be con vidual, group, family, etc.).	Document 44
Service Accessibility	 To promote access, providers may use Telemedicine as a tool to provide direct interventions to individuals for whom English is not their first language. Examples of this include: the use of one-to-one service intervention via Telemedicine, connecting the individual to a practitioner who speaks the individual's language versus use of interpreters; and/or the use of an interpreter via Telemedicine to support the practitioner in delivering the identified service. Telemedicine may only be utilized when delivering this service to an individual for whom English is not their first language. The individual must consent to the use of this modality. This consent should be documented in the individual's record. The use of telemedicine should have practitioner's/agency's convenience or preference. 	48-73 Filed 11/29/23
Billing & Reporting Requirements	 Unsuccessful attempts to make contact with the individual are not billable. When a billable collateral contact is provided, that is documented as a part of the progress note. A collateral contact is classified as any contact that is not face-to-face with the individual. When Telemedicine technology is utilized for the provision of this service in accordance with the allowance in the Service Accessibility section of this definition, the code cited in the Code Detail above with the appropriate GT modifier shall be utilized in documentation and claims submission. 	Page 127
Behavioral	Behavioral Health Assessment	of 627

Behavioral Health Assessment

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Mental Health			_	2	3 4	2		200	-	7	3 4	2	
Assessment by	Practitioner Level 2, In-Clinic Practitioner Level 3, In-Clinic	H0031	U2 U3	9n 9n		\$38.97	Practitioner Level 2, Out-of-Clinic Practitioner Level 3, Out-of-Clinic	H0031	U2 U3	70		\$46.76	
	Practitioner Level 4, In-Clinic	H0031	U4	9N		\$20.30	Practitioner Level 4, Out-of-Clinic	H0031	U4	U2		\$24.36	(
<u></u>	Practitioner Level 5, In-Clinic	H0031	U5	90		\$15.13	Practitioner Level 5, Out-of-Clinic	H0031	U5	U2		\$18.15	Ca
<u> </u>	Practitioner Level 2, Via interactive audio and video	H0031	GT	U2		\$38.97	Practitioner Level 4, Via interactive audio and video	H0031	GT	V4		\$20.30	se 1:
-	telecommunication systems						telecommunication systems						16
<u> </u>	Practitioner Level 3, Via interactive audio and video telecommunication systems	H0031	E	U3		\$30.01	Practitioner Level 5, Via interactive audio and video telecommunication systems	H0031	GT	U5		\$15.13	6-cv-03
Unit Value	15 minutes						Utilization Criteria	TBD					808
- 20	The Behavioral Health Assessme serspective as a full partner, and Sertified Peer Specialists who ha	nt process may also ve been w	s consis include orking v	its of a fai individua with indivi	ce-to-face identified duals on g	comprehensi family and/or oal discovery	The Behavioral Health Assessment process consists of a face-to-face comprehensive clinical assessment with the individual, which must include the individual's perspective as a full partner, and may also include individual-identified family and/or significant others as well as other involved agencies, treatment providers (including Certified Peer Specialists who have been working with individuals on goal discovery), and other relevant individuals.	ridual, whii nvolved ag	ch must gencies,	include treatme	the individual's ent providers (ir	soluding	8-ELR
<u> </u>	The purpose of the assessment preferences, to develop a social (lisability, and to engage with collinguort the determination of a dif	extent of rateral considerential di	to gathe natural s tacts for iagnosis	er all inforsupports ar other as and ass	mation nee and commu sessment i st in scree	ded to deten inity integrati information. A ning for/ruling	The purpose of the assessment process is to gather all information needed to determine the individual's problems, strengths, needs, abilities, resources, and preferences, to develop a social (extent of natural supports and community integration) and medical history, to determine functional level and degree of ability versus disability, and to engage with collateral contacts for other assessment information. A suicide risk assessment shall also be completed. The information gathered should support the determination of a differential diagnosis and assist in screening for/ruling-out potential co-occurring disorders.	ngths, nee ne function be comple rs.	ds, abilit al level eted. Th	ties, res and deg e inform	ources, and gree of ability ve nation gathered	srsus	Document
7 -	As indicated, information from medical, nursing, peer, vocat resulting IRP.	dical, nur	sing, pe	er, vocati	onal, nutrit	ional, etc. sta	ional, nutritional, etc. staff should serve as content basis for the comprehensive assessment and the	the compi	ehensiv	e asses	ssment and the		t 448-
Admission Criteria	 Individual has a known or suspected mental illness or substance-related disorder; and Initial screening/intake information indicates a need for further assessment; and It is expected that individual meets DBHDD service eligibility. 	suspected rmation in al meets D	mental idicates iBHDD	illness or a need fo service e	substance or further av igibility.	related disossessment; a	order; and and						-73 F
Continuing Stay Criteria	Individual's situation/functioning has changed in such a way that previous assessments are outdated.	ias chang	ed in su	ch a way	that previc	us assessme	ents are outdated.						iled
Discharge Criteria	 An adequate continuing care plan has been established; and one or more of the following: Individual has withdrawn or been discharged from service. 	re plan ha r been dis	as been charged	establish I from sei	ed; and or vice.	e or more of	the following:						11/2
Service Exclusions	Assertive Community Treatment												9/23
	 Any diagnosis given to an individual must come from The behavioral health assessment process must incleasesesment, additional collateral information gathere 	individual sssment p lateral info	must corrects in the correct of the	me from must inclu gathere	persons id ide a face- d from the	entified in O.0 to-face compudividual, fro	Any diagnosis given to an individual must come from persons identified in O.C.G.A Practice Acts as qualified to provide a diagnosis. The behavioral health assessment process must include a face-to-face comprehensive clinical assessment with the individual. Beyond this face-to-face assessment, additional collateral information gathered from the individual, from individual-identified family members, significant others, other involved	provide a c the individ ers, signifi	liagnosis ual. Bey cant oth	s. ond this ers, oth	s face-to-face er involved		Page
Components	agencies/treatment providers, and any other relevant 3. An initial Behavioral Health Assessment is required v individual.	ers, and aı า Assessท	ny other nent is r	relevant equired w	individuals ithin the fir	may be colle st 30 days of	agencies/treatment providers, and any other relevant individuals may be collected telephonically. An initial Behavioral Health Assessment is required within the first 30 days of service with ongoing assessments completed as demanded by changes with an individual.	completec	l as den	nanded	by changes wit	h an	228 o
Staffing Requirements	1. Practitioner scope of practice is often defined in law and/or regulation. As such, while U4 and U. certain aspects of assessment must be completed by practitioners licensed or certified to do so	ice is ofter nent must	define be com	d in law a pleted by	nd/or regu practitione	ation. As suc	Practitioner scope of practice is often defined in law and/or regulation. As such, while U4 and U5 practitioners are supporting partners in the assessment process, certain aspects of assessment must be completed by practitioners licensed or certified to do so.	e supportir	ng partn	ers in th	ie assessment	process,	of 627

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2 %	As indicated, medical, nursing, peer, school, nutritional, etc. staff can provide inficomplete the comprehensive nature of the assessment. Time spent gathering the time and need for capturing said information. Addictions counselors/SLID-certified practitioners may deliver this service when	irsing, pee sive natur ng said in:	er, school e of the formation	ol, nutril assess on.		tc. staff Time spi liver this	can provent gathe	etc. staff can provide information from the individual, records, and various multi-disciplinary resources to Time spent gathering this information may be billed as long as the detailed documentation justifies the eliver this service when:	records, a as long as	nd varion the deta	us multi-dis led docum	sciplinary re lentation jus	sources to tifies the	
;	a. A presenting indivi	idual has	a knowr	or sus	spected	substai	nce use d	A presenting individual has a known or suspected substance use disorder (including those with known/suspected co-occurring MH/SUD diagnoses): and/or	n/suspecte	၁၁၀-၀၁ p	urring MH/	SUD diagno	ses):	Ca
	b. The service is delivered at a location wherein it can be known/suspected co-occurring MH/SUD diagnoses);	ivered at a co-occurri	a locatio ing MH/	n where SUD di	ein it ca agnose	n be ex s);	pected th	The service is delivered at a location wherein it can be expected that all individuals presenting have a substance use disorder (including those with known/suspected co-occurring MH/SUD diagnoses); AND	substance	nse disc	order (inclu	nding those	with	ase 1:1
	c. If, during the course of service delivery, there is condition that rises to a certain level of acuity/co coordinated with a partnering U1-U3 level practi	se of servi s to a cert partnerin	ice deliv ain leve g U1-U	ery, the of acu	ere is eviity/com	idence plexity (ner who	of either (e.g. psyc can prov	If, during the course of service delivery, there is evidence of either a singular MH condition (i.e., without a co-occurring SUD), or a co-occurring MH condition that rises to a certain level of acuity/complexity (e.g. psychosis, symptoms of major depression, etc.), then additional assessment should be coordinated with a partnering U1-U3 level practitioner who can provide necessary supporting assessment interventions.	ut a co-occ ion, etc.), t nent interve	urring Shen addi	JD), or a c tional asse	o-occurring ssment sho	MH uld be	6-cv-03
To pron include:	promote access, providers made:	nay use T	elemed	icine as	a tool t	to provic	de direct ì	To promote access, providers may use Telemedicine as a tool to provide direct interventions to individuals for whom English is not their first language. Examples of this include:	m English i	s not the	ir first lang	juage. Exan	ples of this	8808
-	 the use of one-to-one se interpreters; and/or 	ervice inte	rvention	via Te	lemedic	ine, coi	nnecting t	the use of one-to-one service intervention via Telemedicine, connecting the individual to a practitioner who speaks the individual's language versus use of interpreters; and/or	speaks the	individu	al's langua	ige versus u	se of	ELR
-	 the use of an interpreter 	. via Telen	nedicine	to sup	port the	practiti	oner in de	the use of an interpreter via Telemedicine to support the practitioner in delivering the identified service.						
Tele mod prefe	Telemedicine may only be utilize modality. This consent should by preference.	ed when c	deliverir ented in	ig this s the ind	service t ividual's	to an in	dividual fc I. The use	Telemedicine may only be utilized when delivering this service to an individual for whom English is not their first language. The individual must consent to the use of this modality. This consent should be documented in the individual's record. The use of telemedicine should not be driven by the practitioner's/agency's convenience or preference.	iguage. Th	e individ oractition	ual must co er's/agenc	onsent to th y's conveni	e use of this ence or	ocume
←:	In addition to any specific assessment document: supports each claim submitted for this service, in Requirements, 8. Progress Notes of this manual.	assessm nitted for t	ent doc this serv of this m	uments ice, in a	resultir	ng from Ince wit	the delive h <u>Part II -</u>	In addition to any specific assessment documents resulting from the delivery of this service, there must be a Progress Note in the individual's medical record that supports each claim submitted for this service, in accordance with Part II - Community Service Requirements for BH Providers, Section III – Documentation Requirements, 8. Progress Notes of this manual.	Progress Norgress Nor	Vote in the	e individua Section III	al's medical – Documen	record that <u>tation</u>	nt 448-
2.	A provider may submit an authorization request and su	authoriza	ation rec	quest ar	sqns pu	equent	claim for	bsequent claim for BHA for an individual who may have been erroneously referred for assessment and,	ve been en	oneous!	y referred 1	for assessm	ent and,	-73
હ	upon the results of that as When Telemedicine techr the code cited in the Code	ssessmen nology is u	ıt, it is d ıtilized f ɔove wit	etermin or the p	ed that provision ppropris	the per n of this	son does service i nodifier s	upon the results of that assessment, it is determined that the person does not meet eligibility as defined in this manual. When Telemedicine technology is utilized for the provision of this service in accordance with the allowance in the Service Accessibility section of this definition, the code cited in the Code Detail above with the appropriate GT modifier shall be utilized in documentation and claims submission.	is manual. I the Servic Ind claims s	e Acces submissi	sibility sec	tion of this c	lefinition,	File
														d 11
Heal	Health Clinical Consultation	ation												/29
Code	Code Detail	Code	Mod 1	Mod 2	Mod 3	Mod 4	Rate	Code Detail	Code	Mod 1	Mod M	Mod Mod 3 4	Rate)/23
Pract	Practitioner Level 1	99446	LO				\$38.81	Practitioner Level 2	99446	U2			\$25.98	Pag
15 m	15 minutes							Utilization Criteria	TBD					e 1
This phys phys	This service includes an inter-professional telephone consultation between physicians (practitioner le physician/extender with the enrolled DBHDD agency provides or receives specialty expertise opinion physician/extender regarding an individual who is enrolled receiving DBHDD services/supports. The Request/receive a clinical/medical opinion related to the behavioral health condition; and/or	ofessiona olled DBHI individua cal/medic	I telepho DD ager I who is al opinic	ione consulta sucy provides s enrolled rec- ion related to	isultatic vides or d received to the	n betwer receivering DB	en physides special HDD servioral hea	This service includes an inter-professional telephone consultation between physicians (practitioner level 1) and/or physician extenders (practitioner level 2) in which the physician/extender with the enrolled DBHDD agency provides or receives specialty expertise opinion and/or treatment advice to/from another treating physician/extender regarding an individual who is enrolled receiving DBHDD services/supports. The physician/extender colleagues collaboratively confer to: Request/receive a clinical/medical opinion related to the behavioral health condition; and/or	hysician ex ent advice nder collea	tenders to/from a gues col	(practitione nother trea aborativel	er level 2) ir ating y confer to:	which the	.29 of 627

Accessibility Service

Billing & Reporting Requirements

Documentation Requirements

	\ate	\$25.98		vhich the						
	Code Mod Mod Mod Rate	₩		el 2) in v fer to:						
	Mod 3			oner lev reating rely con						
	Mod 2			(practiti another t laborativ						
	Mod 1	U2		tenders to/from a gues col						
	Code	99446 U2	TBD	ysician ex it advice t ler collea						
	Code Detail	Practitioner Level 2	Utilization Criteria	cians (practitioner level 1) and/or ph ty expertise opinion and/or treatmer ices/supports. The physician/extend ith condition; and/or						
	\$38.81 \$\frac{3}{4}\$\$ \$38.81 \$\frac{538.81}{4}\$\$ \$\frac{538.81}{4}									
	Mod 4	sr Level 1 Second Mod Mod Mod Rate Code D \$\text{Start}\$ \$\text{3} \text{4} \\ \$\text{Start}\$								
	Mod 3	99446 U1 \$38.81 F -professional telephone consultation between physicia an individual who is enrolled receiving DBHDD servicial/medical opinion related to the behavioral health/medical provider with diagnosing; and/or								
	Mod 2	-professional telephone consultation between particular DBHDD agency provides or receives span individual who is enrolled receiving DBHDD clinical/medical opinion related to the behavioral health/medical provider with diagnosing; and								
	Mod 1	99446 U1 professional telephone consultation include DBHDD agency provides on an individual who is enrolled receivinical/medical opinion related to the lealth/medical provider with diag								
tion	Code	er-professional telephone ce enrolled DBHDD agency png an individual who is enrolled provider oral health/medical provider								
Behavioral Health Clinical Consultation	Code Detail	Practitioner Level 1	15 minutes	This service includes an inter-professional telephone physician/extender with the enrolled DBHDD agency physician/extender regarding an individual who is enrolled services a clinical/medical opinion reference a clinical/medical provide service a desist the behavioral health/medical provide						
Behavioral	Transaction Code	Interprofessional Telephone Consultation	Unit Value	Service Definition						

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		v-03088-ELR Do	ocument 448-73	Filed 11/29/23	Page 130 of 627
Rebayioral Health Clinical Consultation	 Support/manage the diagnosis and/or management of an individual's presenting condition without the need for the individual's face-to-face contact with the other practitioner; and/or Consult about alternatives to medication, medication combined with psychosocial treatments and potential results of medication usage; and/or Identify and plan for additional services; and/or Coordinate or revise a treatment plan; and/or Understand the complexities of co-occurring medical conditions on the individual's behavioral health recovery plan (e.g. kidney failure, diabetes, high blood pressure, etc.); and/or Reviewing the individual's progress for the purposes of collaborative treatment outcomes. 	 Individual must meet the Admission Criteria elements as defined in the Psychiatric Treatment definition herein; and Individual must be a registered recipient of DBHDD services (in the Georgia Collaborative ASO system); and Individual must have a condition or presentation of symptoms that require the advice, opinion, and/or coordination with a supporting physician/extender. Individual continues to meet the admission criteria; or Individual exhibits acute disabling conditions of sufficient severity to bring about a significant impairment in day-to-day functioning; or Individual continues to present symptoms that are likely to respond or are responding to medical interventions; or Individual continues to demonstrate symptoms that are likely to respond or are responding to medical interventions; or Individual continues to require management of pharmacological treatment in order to maintain symptom remission. 	divic divic		 a. Individual demographics; b. Date and results of initial or most recent behavioral health evaluation; c. Diagnosis and/or presenting behavioral health condition(s); d. Prescribed medications; and e. Supporting health providers' name and contact information. 3. The consultant providing medical guidance and advice should have the following credentials and skillset: a. Licensed and in good standing with the Georgia Composite Medical Board; b. Ability to recognize and categorize symptoms;
Rehavior		Admission Criteria Continuing Stay Criteria	Discharge Criteria Clinical Exclusions Required Components	Staffing Requirements	Clinical Operations

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havioral	He	Behavioral Health Clinical Consultation	
	4.	 d. Ability to initiate transfers to medical services; and e. Ability to assist with disposition planning. i. The advice and/or guidance of the consultant should be considered during treatment/recovery and discharge planning, and clearly documented in the individual's 	
	_	medical record.	Ca
Service Accessibility	2 –	. Services are available 24-hours/day, / days per week, and offered by telephone; and Demographic information collected shall include a preliminary determination of hearing status to determine referral to DBHDD Office of Deaf Services.	ase
	_	Requests between the practitioners (or their representatives) may be written or verbal. Either type of request shall be documented in the individual's medical record and noted as an administrative note (i.e., no charge).	1:16
	- 2	 In addition to all elements defined in this provider manual for the documentation of an encounter, for this service additional elements required are as follows: a. The DBHDD enrolled agency physician/extender who requests a consultation from an external provider should clearly document: i. The External Physician/Extender pages and energially practice and specially practice and energially practices. 	-cv-03
Documentation Requirements		ii. A justification of signs, symptoms, or other co-morbid health interactions that reflect why the consultation was requested; and iii. Advice, guidance, and/or result of the consulting behavioral health provider consultation.	088-E
		 When a practitioner external to the DBHDD enrolled agency requests a consultation from the DBHDD enrolled agency physician/extender, the practitioner should clearly document the following: 	ELR
		I. The External Physician/Extender name and specialty practice area; and ii. The requesting reason for the consultation, medical advice and/or guidance provided to the healthcare provider; and iii. Any collaborative outcome/plan which will impact the overall IRP.	Docun
Billing &	-	The only practitioners who can bill this service are Physicians and Physician extenders who work for a Tier I or Tier II provider who is approved to deliver Physician Assessment services through the DBHDD.	nent
Requirements	5.	The DBHDD enrolled provider must consult with an external Physician/Extender (e.g., emergency department, primary care, etc.). In other words, billing for internal consultations are not permitted through this code.	448-
			73

Case Management	ement												
Transaction Code	Code Detail	Code	Mod 1	Mod 2	ModModModRate234	Rate	Code Detail	Code	Mod 1	Mod Mod Mod 1 2 3		Mod Rate 4	Rate
	Practitioner Level 4, In-Clinic	T1016 U4	U4	90		\$20.30	Practitioner Level 4, In-Clinic, Collateral Contact	T1016	UK U4	U4	90		\$20.30
	Practitioner Level 5, In-Clinic	T1016 U5	U5	90		\$15.13	Practitioner Level 5, In-Clinic, Collateral Contact	T1016	UK U5	O15	90		\$15.13
Case Management	Practitioner Level 4, Out-of-Clinic	T1016 U4	U4	U7		\$24.36	Practitioner Level 4, Out-of-Clinic, Collateral Contact	T1016 UK U4	놀		U7		\$24.36
)	Practitioner Level 5, Out-of-Clinic T1016 U5	T1016	U5	U7		\$18.15	Practitioner Level 5, Out-of-Clinic, Collateral Contact	T1016 UK U5	¥		U7		\$18.15
	Practitioner Level 4, Via interactive audio and video telecommunication systems	T1016 GT	GT	U4		\$20.30	Practitioner Level 5, Via interactive audio and video telecommunication systems	T1016	GT U5	U5			\$15.13
Unit Value	15 minutes						Utilization Criteria	24 units					

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	minimity to services and resolutions in our interpreted planning process, 4) coordinating services identified on the investment of the IRP to meet his/her ongoing and changing needs.	Case
	The performance outcome expectations for individuals receiving this service include decreased hospitalizations, decreased incarcerations, decreased episodes of homelessness, increased housing stability, increased participation in employment or job-related activities, increased community engagement, and recovery maintenance.	1:16-cv-
	Case Management Services shall consist of four (4) major components that cover multiple domains that impact one's overall wellness including medical, behavioral, wellness, social, educational, vocational, co-occurring, housing, financial, and other service needs of the individual:	03088-
O. D.	Engagement & Needs Identification The case manager engages the individual in a recovery-based partnership that promotes personal responsibility and provides support, hope, and encouragement. The case manager engages the individual with developing a community-based support network to facilitate community integration and maintain housing stability. Through engagement, the case manager partners with the individual to identify and prioritize housing, service and resource needs to be included in the IRP.	ELR Doo
Definition	Care Coordination The case manager coordinates care activities and assists the individual as he/she moves between and among services and supports. Care coordination requires information sharing among the individual, his/her Tier 1 or Tier 2 provider, specialty provider(s), residential provider, primary care physician, and other identified supports in order to: 1) ensure that the individual receives a full range of integrated services necessary to support a life in recovery that includes health, home, purpose, and community, 2) ensure that the individual has an adequate and current crisis plan; 3) reduce barriers to accessing services and resources; 4) minimize disruption, fragmentation, and gaps in service; and 5) ensure all parties work collaboratively for the common benefit of the individual.	cument 448-73
	Referral & Linkage The case manager assists the individual with referral and linkage to services and resources identified on the IRP including housing, social supports, family/natural Supports, entitlements (SSI/SSDI, Food Stamps, VA), income, transportation, etc. Referral and linkage activities may include assisting the individual to: 1) locate available resources; 2) make and keep appointments; 3) complete the application process; and 4) make transportation arrangements when needed.	Filed 11/2
	Monitoring and Follow-Up The case manager visits the individual in the community to jointly review progress made toward achievement of IRP goals and to seek input regarding his/her level of satisfaction with treatment and any recommendations for change. The case manager monitors and follows-up with the individual in order to: 1) determine if services are adequately and effectively addressing the individual's needs; 3) determine the need for additional or	29/23 Pa
	ateriaive services related to the marviduals changing needs of chambiances, and 4) notify the treatment team when mornioung marcates the need for increassessment and update.	ge 1
	1. Individual must meet DBHDD eligibility criteria; AND	.32 o
Criteria	2. Individual has functional impairments that interfere with maintaining their recovery and needs assistance with one (1) or more of the following areas: a. Navigate and self-manage necessary services;	of 627
	b. Maintain personal hygiene;	7

Case Management

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Case Management	ement	
	c. Meet nutritional needs; d. Care for personal business affairs; e. Obtain or maintain medical, legal, and housing services; f. Recognize and avoid common dangers or hazards to self and possessions; g. Perform daily living tasks; h. Obtain or maintain employment at a self-sustaining level or consistently perform homemaker roles (e.g., household meal preparation, washing clothes, budgeting, or childcare tasks and responsibilities); i. Maintain a safe living situation: AND 3. Individual is engaged in their Recovery Plan but demonstrates difficulty implementing the plan which has led to the exacerbation of problematic symptoms. Individual needs assistance with one (1) or more of the following areas in order to successfully implement their Recovery Plan and maintain their recovery: a. Taking prescribed medications; or b. Following a crisis plan; or c. Maintaining community integration; or d. Keeping appointments with needed services.	Case 1:16-cv-03088-ELR
Continuing Stay Criteria	 Individual continues to have a documented need for CM interventions at least twice monthly; and Individual continues to meet the admission criteria; or Continued difficulty participating in traditional clinic-based services or a community setting at a less intensive level of service/support; or Living in substandard housing, homeless, or at imminent risk of becoming homeless due to functional impairments associated with behavioral health issues. 	Docum
	 There has been a planned reduction of units of service delivered and related evidence of the individual sustaining functioning through that reduction plan; and Individual has established recovery support networks to assist in maintenance of recovery (such as peer supports, AA, NA, etc.); and Individual has demonstrated ownership and engagement with her/his own illness self-management as evidenced by: Navigating and self-managing necessary services; Maintaining personal hygiene; Meeting his/her own nutritional needs; 	ent 448-73
Discriatge Criteria	 d. Caring for personal business affairs; e. Obtaining or maintaining medical, legal, and housing services; f. Recognizing and avoiding common dangers or hazards to self and possessions; g. Performing daily living tasks; h. Obtaining or maintaining employment at a self-sustaining level or consistently performing homemaker roles (e.g., household meal preparation, washing clothes, budgeting, or childcare tasks and responsibilities); and i. Maintaining a safe living situation. 	Filed 11/29/23
Service Exclusions	 This service may not duplicate any discharge planning efforts which are part of the expectation for hospitals, Intermediate Care Facilities for Individuals with Intellectual Disabilities (IFC/IID), Institutions for Mental Disease (IMDs), and Psychiatric Residential Treatment Facilities (PRTFs). This service is not available to any individual who receives a waiver service via the Department of Community Health. Payment for Intensive Case Management Services under the plan shall not duplicate payments made to public agencies or private entities under other program authorities for this same purpose. Individuals with a substance-related disorder are excluded from receiving this service unless there is clearly documented evidence of a psychiatric diagnosis. ACT, CST, ICM are service exclusions. Individuals may receive CM and one of these service for a limited period of time to facilitate a smooth transition. 	Page 133 o
Clinical Exclusions	Individuals with the following conditions are excluded from admission unless there is clearly documented evidence of a psychiatric condition co-occurring with the diagnosis of: Intellectual/Developmental Disabilities; and/or Autism; and/or Neurocognitive Disorder; and/or Traumatic Brain Injury.	f 627

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and oocumented, the provider maximum of a maximum of one (1) telephone contact in mat specified monin (denoted by the UK modiner). Billing of contacture days. After four (4) unsuccessful attempts at making face to face contact with an individual, the CM and members of the treatment team will re-evaluate the IRP and utilization of services. In the event that a CM has documented multiple attempts to locate and make contact with an individual and has demonstrated diligent search, after 60 days of unsuccessful attempts the individual may be dischaged. In the event that a CM has documented multiple attempts to locate and make contact with an individual and has demonstrated diligent search, after 60 days of unsuccessful attempts the individual may be dischaged. When the primary focus of CM is on medication maintenance, the following allowances apply: These individuals are not counted in the off-site service requirement, however, a minimum of one (1) face-to-face contact is required every three (3) months; and monthly calls are an allowed billable service. Oversight of CM is provided by an independently licensed practitioner. It is recommended that the CM caseload not exceed 50 enrolled individuals. Appraisationer delivering Case Management should be able to provide skills training when needed by the individual, but the skills training activity must be billed as PSR-1 and not Case Management. CM may include (with the consent of the Adult) coordination with family and significant others and other systems/supports (e.g., work, religious entities, corrections, aging agencies, act.) when appropriate for treatment and recovery needs. CM providers must have the ability to deliver services in various environments, such as homes, homeless shelters, or street locations. The provider should keep in mindividuals may prefer to meet staff at a community location other than their homes or other conspicuous locations (e.g., their place of employment) in mind that individuals may prefer to meet staff at a community location	and accumented, the provided may print or a maximum or one (1) telephone contact in that specified month (genoted by the UN modified contact only may not exceed 30 consecutive days. 10. After four (4) unsuccessful attempts at making face to face contact with an individual and has demonstrated diligent sean utilization of services. 11. In the event that a CM has documented multiple attempts to locate and make contact with an individual and has demonstrated diligent sean unsuccessful attempts the individuals for whom there is a written transition/discharge plan may receive a tapered benefit based upon individualized need as document 12. Individuals for whom there is a written transition/discharge plan may receive a tapered benefit based upon individualized need as document 13. When the primary focus of CM is on medication maintenance, the following allowances apply: a. These individuals are not counted in the off-site service requirement; however, a minimum of one (1) face-to-face contact three (3) months; and monthly calls are an allowed billable service. 1. Oversight of CM is provided by an independently licensed practitioner. 2. It is recommended that the CM caseload not exceed 50 enrolled individuals. 3. Individuals who receive only medication maintenance are not counted in the staff ratio calculation. 4. A practitioner delivering Case Management. 7. CM may include (with the consent of the Adult) coordination with family and significant others and other systems/supports (e.g., work, religit or CM may include (with the consent of the Adult) coordination with family and significant others and other systems/supports (e.g., work, religit or CM may include (with the consent of the Adult) coordination with family and significant others and other systems/supports (e.g., work, religit or CM may include (with the consent of the Adult) coordination with family and significant others and other systems, homeless shelters, or street locations (e.g., their pie especially if staff drive a vehicle that is clearly mar
contact only may not exceed 30 consecutive days. After four (4) unsuccessful attempts at making face to face contact with ar utilization of services. In the event that a CM has documented multiple attempts to locate and munsuccessful attempts the individual may be discharged. Individuals for whom there is a written transition/discharge plan may received the primary focus of CM is on medication maintenance, the following as an endividual sare not counted in the monthly face-to-face contact three (3) months; and monthly calls are an allowed billable service. Oversight of CM is provided by an independently licensed practitioner. It is recommended that the CM caseload not exceed 50 enrolled individual Individuals who receive only medication maintenance are not counted in the A practitioner delivering Case Management should be able to provide skills PSR-I and not Case Management. CM may include (with the consent of the Adult) coordination with family an corrections, aging agencies, etc.) when appropriate for treatment and reco CM providers must have the ability to deliver services in various environment in mind that individuals may prefer to meet staff at a community location of especially if staff drive a vehicle that is clearly marked as a state or agency individual in a way that may botentially embarrass the individual or breech	
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Case Management

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Case Management	individuals' privacy/confidentiality rights and preferences in this regard to the greatest extent possible (e.g. if staff must meet with an individual during their work time, if the individual wishes, mutually agree upon a meeting place nearby that is the least conspicuous from the individual's point of view). CM is expected to participate in planning, coordinating, and accessing services and resources when an enrolled individual experience an episode of psychiatric	
4	hospitalization, incarceration, and/or homelessness. It is expected that the individual served will receive ongoing physician assessment and treatment as well as other recovery-supporting services. These services may be provided by a Tier 1 or Tier 2 Provider or by an external agency. There shall be documentation during each Authorization Period to demonstrate the	Case 2
ry o	team s efforts at consulting and collaborating with the physician and other recovery-supporting services. It is expected that the Case Management practitioner will assist all eligible individuals with the application process to obtain entitlement benefits including SSI/SSDI, Food Stamps, VA, Medicaid, etc. including making appointments, completing applications and related paperwork.	L:16-cv
6. 7.	I he organization must have policies that govern the provision of services in natural settings and can document that the organization respects individuals' rights to privacy and confidentiality when services are provided in these settings. The organization has established procedures/protocols for handling emergency and crisis situations that includes:	-03088
	 a. Joint development of a crisis plan between the Individual, organization, then I or then 2 provider, and other providers where the organization is engaged with the individual to ensure that the plan is complete, current, adequate, and communicated to all appropriate parties; and b. An evaluation of the adequacy of the individual's crisis plan and its implementation occurs at periodic intervals including post-crisis events. i. While respecting the individual's crisis plan and identified points of first response, the policies should articulate the role of the Tier 1 or Tier 2 provider. 	-ELR
φ.	The orç	Docu
	 a. Description of the role of a Case Management practitioner during a crisis in partnership with the individual's other service providers either within the agency or with an outside clinical home where the individual receives ongoing physician assessment and treatment, as well as other recovery support services: 	ıment
		448-7
	c. Description of the nouts of operations as related to access and availability to the individuals served; d. Description of how the IRP plan constructed, modified and/or adjusted to meet the needs of the individual and to facilitate broad natural and formal support	3
	participation; and e. Description of how CM agencies engage with other agencies who may serve the target population.	File
2 , 7	There must be documented evidence that service hours of operation include evening, weekend, and holiday hours. "Medication Maintenance Track," individuals who require more than 4 contacts per quarter for two consecutive quarters (as based upon need) are expected to be re-evaluated with the ANSA for enhanced access to CM. The designation of "medication maintenance track" should be lifted and exceptions stated above are no	d 11/29
<i>к</i> і	`	9/23
Service Accessibility	of one-to-one service intervention via Telemedicine, connecting the individual to a practitioner who speaks the individual's language versus use of ters; and/or	Page
	the use of an interpreter via Telemedicine to support the practitioner in delivering the identified service.	135
	Telemedicine may only be utilized when delivering this service to an individual for whom English is not their first language. The individual must consent to the use of this modality. This consent should be documented in the individual's record. The use of telemedicine should not be driven by the practitioner's/agency's convenience or preference.	of 627

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ng modifier shall be	ded, the UK reporti	late	nent 1. When a billab with the indivi	anager	Case Ma		Case Management	eral conta	DIIIIII & with the individual
utilized. A collateral contact is classifled	ng modifier shall be utilized. A collateral contact is classified	ed, the UK reporting modifier shall be utilized. A collateral co	lateral contact is provided, the UK reporting modifier shall be utilized. A collateral co	able collateral contact is provided, the UK reporting modifier shall be utilized. A collateral co	able collateral contact is provided, the UK reporting modifier shall be utilized. A collateral co	able collateral contact is provided, the UK reporting modifier shall be utilized. A collateral co		act t	
utilized. A collateral	ng modifier shall be utilized. A collateral	ed, the UK reporting modifier shall be utilized. A	lateral contact is provided, the UK reporting modifier shall be utilized. A	able collateral contact is provided, the UK reporting modifier shall be utilized. A	able collateral contact is provided, the UK reporting modifier shall be utilized. A	able collateral contact is provided, the UK reporting modifier shall be utilized. A		contact is classified	
	ng modifier shall be	ided, the UK reporting modifier shall be	lateral contact is provic	able collateral contact is provic	able collateral contact is provic	able collateral contact is provic		utilized. A collateral	

is not face-to-face

When Telemedicine technology is utilized for the provision of this service in accordance with the allowance in the Service Accessibility section of this definition, the code cited in the Code Detail above with the appropriate GT modifier shall be utilized in documentation and claims submission. with the individual. ς;

Reporting Requirements

Community	Community Transition Planning													
Transaction Code	Code Detail	Code	Mod 1	Mod I	Mod I	Mod 4	Rate	Code Detail	Code	Mod 1	Mod	Mod N	Mod Rate 4	
Community Transition	Community Transition Planning (State Hospital)	T2038	ZH				\$20.92	Community Transition Planning (Jail /Prison)	T2038	ZJ			\$20.92	92
Planning	Community Transition Planning (CSU)	T2038	ZC				\$20.92	Community Transition Planning (Other)	T2038	ZO			\$20.92	92
Unit Value	15 minutes													
	Community Transition Planning (CTP) mental health and/or substance use d contact with the individual and their id hospital/facility. Additional Transition service agency; participating in state t community resources when indicated.	CTP) is a use disord eir identification Plann tate hospil ated.	service ler to en ed supp ining activ tal or fac	for confaure a corts with orts with vities incorting treatments	racted coording a mini slude ec	Tier 1/ ⁷ ated pla imum c imum c ducatin team r	Tier 2 and 1 an of transil of one (1) fe g the indivi neetings to	Community Transition Planning (CTP) is a service for contracted Tier 1/Tier 2 and ACT providers to address the care, service, and support needs of adults with a mental health and/or substance use disorder to ensure a coordinated plan of transition from a qualifying facility to the community. Each episode of CTP must include contact with the individual and their identified supports with a minimum of one (1) face-to-face or telephonic contact with the individual prior to release from the state hospital/facility. Additional Transition Planning activities include educating the individual and identified supports on service options offered by the chosen primary service agency; participating in state hospital or facility treatment team meetings to develop a transition plan, and making collateral contacts with other agencies and community resources when indicated.	ervice, and mmunity. the indivic ce options g collatera	d suppo Each el dual prid offered	rt needs oisode of or to rele: I by the c	of adulti CTP m ase fron thosen p	s with a ust include I the state rimary encies and	
	In partnership between other community service providers and transitional activities either by the individual's chosen primary also be used for Case Management/ICM/AD Support Services with the individual in the future to maintain or establish contact	nmunity se individua ent/ICM/A maintain	ervice prairs chos It's chos ID Suppa or estat	roviders en prim ort Serv oltsh con	and the ary ser- ices statact.	e hospi vice co aff, AC ⁻	ital/facility s ordinator o	In partnership between other community service providers and the hospital/facility staff, the community service agency maintains responsibility for carrying out transitional activities either by the individual's chosen primary service coordinator or by the service coordinator's designated Community Transition Liaison. CTP may also be used for Case Management/ICM/AD Support Services staff, ACT/CST team members and CPSs who work with the individual in the community or will work with the individual in the future to maintain or establish contact.	naintains rated Comn the indivic	respons nunity T dual in t	ibility for ransition he comm	carrying Liaison unity or	out . CTP may will work	>
Service Definition	CTP consists of the following interventions to ensure 1. Establishing a connection or reconnection with develop and strengthen a foundation for the th	erventions or reconne oundation	to ensu ction wi for the t	re the p th the po therapeu	erson t erson th utic rela	the person transition the person through serapeutic relationship	ons success supportive ip.	CTP consists of the following interventions to ensure the person transitions successfully from the facility to their local community: 1. Establishing a connection or reconnection with the person through supportive contacts while in the qualifying facility. By engaging with the person, this helps to develop and strengthen a foundation for the therapeutic relationship.	mmunity: ty. By enga	aging w	ith the pe	erson, th	is helps to	
	 Educating the person and his/her ider community. This allows the person to likelihood of post-facility engagement. 	is/her ide person to gagement	intified s make s	upports self-dire	about l cted, in:	local cc formed	ommunity re choices or	Educating the person and his/her identified supports about local community resources and service options available to meet their needs upon transition into the community. This allows the person to make self-directed, informed choices on service options that they feel will best meet their needs and increases the likelihood of post-facility engagement.	le to meet st meet th	their ne eir nee	eds upo ds and in	n transil creases	ion into the the	a)
	Participating in qualifying facility team meeting information related to estimated length of stay, extranglise available supports and assets median.	acility tean ated length	n meetin th of sta	igs espe y, prese	ecially in	n perso Ilems re	on centered slated to ac	Participating in qualifying facility team meetings especially in person centered planning for those in a treatment facility, to share hospital and community information related to estimated length of stay, present problems related to admission, discharge/release criteria, progress toward recovery goals, personal strengths are and assets medical condition medication issues and community treatment pends.	ility, to sha progress to	are hos	pital and ecovery g	commu yoals, pe	nity ersonal	
	4. Linking the adult with comm	nunity serv	vices inc	uding v	risits be	tween.	the person	Linking the adult with community services including visits between the person and the CM/ICM/AD Support Services staff, ACT/CST team members and/or CPSs	es staff, A	CT/CS	F team m	embers	and/or CP	Ss
	who will be working with the	e individus	al in the	commu	nity (inc	cluding	visits and the	who will be working with the individual in the community (including visits and telephone contacts between the individual and the community-based providers).	idual and i	the con	ımunity-b	ased pr	oviders).	
Admission Criteria	. <u>≅</u>	igibility wh	ille in on	e of the	followi	ng qua	of the following qualifying facilities:	ties:						

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		С	as	e	1:1	L6-	CV-	0;	30	88	-E	LF	?		Do	CI	um	nei	nt -	44	8-7	73		F	ile	d :	11/	29	9/2	3		Pa	ago	e :	L3	3 0	of 6	2
Rate	\$74.09	\$46.76	\$36.68	\$24.36	\$ 18.15		\$20.30			\$15.13					\$116.42		\$77.94		\$60.02		\$148.18		\$93.52		\$73.36		\$116.42				\$77.94				\$60.02			
Mod Mod 3 4																																						
Mod 2	U2	U2	U2	U2	U2		2			22					U2		U2		U2		U2		U2		U2		7			9	7				<u>2</u>			
Mod 1	U	N2	U3	U4	N2		GT		ļ	5					7		U2		n3		U1		U2		N3		GT			I	5				GT			
Code	H2011	H2011	H2011	H2011	H2011		H2011			H2011					90840		90840		90840		90840		90840		90840		90840				90840				90840			
Code Detail	Practitioner Level 1, Out-of-Clinic	Practitioner Level 2, Out-of-Clinic	Practitioner Level 3, Out-of-Clinic	Practitioner Level 4, Out-of-Clinic	Practitioner Level 5, Out-of-Clinic	Practitioner Level 4, Via	interactive audio and video	telecommunication systems	Practitioner Level 5, Via	interactive audio and video	telecommunication systems				Practitioner Level 1, Out-of-Clinic,	add-on each additional 30 mins.	Practitioner Level 2, Out-of-Clinic,	add-on each additional 30 mins.	Practitioner Level 3, Out-of-Clinic,	add-on each additional 30 mins.	Practitioner Level 1, Out-of-Clinic,	add-on each additional 30 mins.	Practitioner Level 2, Out-of-Clinic,	add-on each additional 30 mins.	Practitioner Level 3, Out-of-Clinic,	add-on each additional 30 mins.	Practitioner Level 1, Via	interactive audio and video	telecommunication systems, add-	on each additional 30 mins	Practitioner Level 2, Via	interactive audio and video	telecommunication systems, add-	on each additional 30 mins	Practitioner Level 3, Via	interactive audio and video	telecommunication systems, add-	on each additional so mins
Rate	\$58.21	\$38.97	\$30.01	\$20.30	\$15.13		\$58.21		1	\$38.97			\$30.01		\$232.84		\$155.88		\$120.04		\$296.36		\$187.04		\$146.72		\$232.84			00	\$155.88				\$120.04			
Mod 4																																						
Mod 3																																						
d Mod	90	90	90	9N	90		2		:	05			<u> </u>		90		90		9N		90		90		90		5			1	0.5				<u> </u>			_
Mod 1	U 1	U2	U3	U4	U5		GT			5			GT		5		U2		U3		U1		U2		N3		GT			1	<u>.</u>				GT			
Code	H2011	H2011	H2011	H2011	H2011		H2011			H2011			H2011		90839		90839		90839		60836		90839		60836		90839				90839				90839			
Code Detail	Practitioner Level 1, In-Clinic	Practitioner Level 2, In-Clinic	Practitioner Level 3, In-Clinic	Practitioner Level 4, In-Clinic	Practitioner Level 5, In-Clinic	Practitioner Level 1, Via	interactive audio and video	telecommunication systems	Practitioner Level 2, Via	interactive audio and video	telecommunication systems	Practitioner Level 3, Via	interactive audio and video	telecommunication systems	Practitioner Level 1, In-Clinic,	first 60 minutes (base code)	Practitioner Level 2, In-Clinic,	first 60 minutes (base code)	Practitioner Level 3, In-Clinic,	first 60 minutes (base code)	Practitioner Level 1, In-Clinic,	first 60 minutes (base code)	Practitioner Level 2, In-Clinic,	first 60 minutes (base code)	Practitioner Level 3, In-Clinic,	first 60 minutes (base code)	Practitioner Level 1, Via	interactive audio and video	telecommunication systems		Practitioner Level 2, Via	interactive audio and video	telecommunication systems		Practitioner Level 3, Via	interactive audio and video	telecommunication systems	
Transaction Code						:	Crisis	ווונפו אפווווסוו																		Psychotherapy	for Crisis											

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Crisis Intervention	ention					_
	Crisis Intervention	15 minutes		Crisis Intervention	16 units	
Unit Value	Psychotherapy for Crisis	1 Encounter	Maximum Daily Units	Psychotherapy for Crisis, base code Psychotherapy for Crisis, add-ons	2 encounters 4 encounters	Ca
Utilization Criteria	TBD					se 1
	Crisis Intervention supports the individual and which is in the direction of severe imphospitalization. Often, a crisis exists at suresources, or practitioner identifies the sit appropriate links to alternate services.	Crisis Intervention supports the individual who is experiencing an abrupt and substantial change in behavior which is usually associated with a precipitating situation and which is in the direction of severe impairment of functioning or a marked increase in distress. Interventions are designed to prevent out of community placement or hospitalization. Often, a crisis exists at such time as an individual and his/her identified natural resources decide to seek help and/or the individual, identified natural resources, or practitioner identifies the situation as a crisis. Crisis services are time-limited and present-focused to address the immediate crisis and develop appropriate links to alternate services.	itial change in behavior which is use in distress. Interventions are desed natural resources decide to seel mited and present-focused to addr	sually associated with a precipiligned to prevent out of commuk help and/or the individual, ideses the immediate crisis and d	tating situation nity placement or entified natural levelop	:16-cv-03088
Service Definition	The individual's current behavioral health care advanced the individual's wishes/choices by following the plan/advaduring the Behavioral Health Assessment/IRP process shelp prevent or manage future crisis situations.		directive, if existing, should be utilized to manage the crisis. Interventions provided should honor and respect anced directive as closely as possible in line with clinical judgment. Plans/advanced directives developed nould be reviewed and updated (or developed if the individual is a new consumer) as part of those services to	iterventions provided should horent. Plans/advanced directives is a new consumer) as part of t	onor and respect s developed those services to	B-ELR D
	Some examples of interventions that may help relieve emotional distress; effective vindividual (to the extent he or she is capal services deemed necessary to effectively issues to be addressed.	Some examples of interventions that may be used to de-escalate a crisis situation could include: a situational assessment; active listening and empathic responses to help relieve emotional distress; effective verbal and behavioral responses to warning signs of crisis related behavior, assistance to, and involvement/participation of the individual (to the extent he or she is capable) in active problem solving planning and interventions; facilitation of access to a myriad of crisis stabilization and other services deemed necessary to effectively manage the crisis; mobilization of natural support systems; and other crisis interventions as appropriate to the individual and issues to be addressed.	uld include: a situational assessme signs of crisis related behavior; as interventions; facilitation of access upport systems; and other crisis in	ent; active listening and empath ssistance to, and involvement/p to a myriad of crisis stabilization terventions as appropriate to the	hic responses to varticipation of the on and other he individual and	Oocument 448
Admission Criteria	Treatment at a lower intensity has been attempted or g Individual has a known or suspected mental health dia Individual is experiencing severe situational crisis and following: a. Individual has insufficient or severely limited resc b. Individual demonstrates lack of judgment and/or		iven serious consideration; and #2 and/or #3 are met: gnosis or Substance Related Disorder; or is at risk of harm to self, others and/or property. Risk ranges from mild to imminent; and one/both of the urces or skills necessary to cope with the immediate crisis; or impulse control and/or cognitive/perceptual abilities.	rom mild to imminent; and one	s/both of the	3-73 Filed 1
Continuing Stay Criteria	This service may be utilized at various po service that stabilizes the individual and n	This service may be utilized at various points in the individual's course of treatment and recovery; however, each intervention is intended to be a discrete time-limited service that stabilizes the individual and moves him/her to the appropriate level of care.	nd recovery; however, each interve.	ention is intended to be a discr	ete time-limited	1/29/
Discharge Criteria	 Individual no longer meets continued stay guidelines; Crisis situation is resolved and an adequate continuir 	Individual no longer meets continued stay guidelines; and Crisis situation is resolved and an adequate continuing care plan has been established	lished.			23
Clinical Exclusions	Severity of clinical issues precludes provision of services	sion of services at this level of care.				Pag
Clinical Operations	In any review of clinical appropriateness of the service, the Organization in combination with other supporting service continues, it is expected that 4 units of crisis is billed and interval of service.		ne mix of services offered to the individual is key. Crisis units will be looked at by the Administrative Services ss. For example, if an individual present in crisis and the crisis is alleviated within an hour but ongoing support then some supporting service such as individual counseling will be utilized to support the individual during that	ill be looked at by the Administ is alleviated within an hour but ill be utilized to support the ind	trative Services congoing support lividual during that	ge 139 of
Staffing Requirements	90839 and 90840 are only utilized wh who are recognized as practitioners fc	 90839 and 90840 are only utilized when the content of the service delivered is Crisis Psychotherapy. Therefore, the only practitioners who can do this are those who are recognized as practitioners for Individual Counseling in the Service X Practitioner Table A included herein. 	isis Psychotherapy. Therefore, the actitioner Table A included herein.	only practitioners who can do	this are those	627

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idual served and cannot provide services to other	unity hospital, clinic		or who speaks the individual's language versus use of 600000000000000000000000000000000000	to the use of	Docum	ne telephonic intervention is not expending the additional 448-	AND		25 25 26 once in a single day. Anything less than 45 minutes 77 28 29 29 29 29 29 29 29 29 29 29 29 29 29	v be billed.	
Ition . The practitioner who will bill 90839 (and 90840 if time is necessary) must devote full attention to the individual served and cannot provide services to other individuals during the time identified in the medical record and in the related claim/encounter/submission.	All crisis service response times for this service must b Services are available 24-hours/day, 7 days/week, and etc.).	 Demographic information collected shall include a preliminary determination of hearing status to determine referral to the Office of Deaf Services. To promote access, providers may use Telemedicine as a tool to provide direct interventions to individuals for whom English is not their first language. Examples of this include: 	 the use of one-to-one service intervention via Telemedicine, connecting the individual to a practitioner who speaks the individual's language versus use of interpreters; and/or the use of an interpreter via Telemedicine to support the practitioner in delivering the identified service. 	Telemedicine may only be utilized when delivering this service to an individual for whom English is not their first language. The individual must consent to the use of telemedicine should not be driven by the practitioner's/agency's convenience or preference.	The daily maximum within a CSU for Crisis Intervention is 8 units/day.	 Any use of a telephonic intervention must be coded/reported with a U6 modifier as the person providing the telephonic intervention is not expending the additional agency resources in order to be in the community where the person is located during the crisis. Any use beyond 16 units will not be denied but will trigger an immediate retrospective review. Psychotherapy for Crisis (90839, 90840) may be billed if the following criteria are met: 	, a		practitioners. The 90839 code is utilized when the time of service ranges between 45-74 minutes and may only be utilized once in a single day. Anything less than 45 minutes can be provided either through an Individual Counseling code or through the H2011 code above (whichever best reflects the content of the intervention). Add-on Time Specificity:	b. If the additional time spent (above base code) is 45 minutes or greater, a second unit of 90840 may be billed. c. If the additional time spent (above base code) is 83 minutes or greater, a third unit of 90840 may be billed.	 If the additional time spent (above base code) is 113 millures of greater, a fourtribulity of 30040 may be billed. 90839 and 90840 cannot be submitted by the same practitioner in the same day as H2011 above. 90839 and 90840 cannot be provided/submitted for billing in the same day as 90791, 90792, 90833, or 90836.
Crisis Intervention 2. The individual indiv	2. 7.		Service Accessibility		Additional Medicaid Tequirements	2		4.	Billing & 5. Reporting 5. Requirements 6		7.

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Crisis Intervention

10. When Telemedicine technology is utilized for the provision of this service in accordance with the allowance in the Service Accessibility section of this definition, the code cited in the Code Detail above with the appropriate GT modifier shall be utilized in documentation and claims submission.

Diagnostic Assessment	Assessment												
Transaction Code	Code Detail	Code	Mod 1	Mod 2	Mod 3	Mod 4	Rate	Code Detail	Code	Mod 1	Mod 2	Mod Mod 3 4	l Rate
Psychiatric	Practitioner Level 2, In-Clinic Practitioner Level 2, Out-of-Clinic	90791	U2 U2	9N 07			\$116.90	Practitioner Level 3, In-Clinic Practitioner Level 3, Out-of-Clinic	90791	EN EN	9N 1		\$90.03
Evaluation (no medical service)	Practitioner Level 2, Via interactive audio and video telecommunication systems	90791	GT	U2			\$116.90	Practitioner Level 3, Via interactive audio and video telecommunication systems*	90791	GT	n3		\$90.03
Psychiatric Diagnostic	Practitioner Level 1, In-Clinic	90792	11	90			\$174.63	Practitioner Level 2, Via interactive audio and video telecommunication systems	90792	GT	N2		\$116.90
Evaluation with	Practitioner Level 1, Out-of-Clinic	90792	N1	U2			\$222.26	Practitioner Level 2, In-Clinic	90792	U2	9N		\$116.90
medical services)	Practitioner Level 1, Via interactive audio and video telecommunication systems	90792	GT	U1			\$174.63	Practitioner Level 2, Out-of-Clinic	90792	U2	U7		\$140.28
Unit Value	1 encounter							Utilization Criteria	TBD				
O Circuit	Psychiatric diagnostic interview examination include between behavioral and physical health care issues) differential diagnosis) screening and/or assessment	amination nealth care	include issues	s a histo); psych	ory; me iatric di	ntal sta agnosti	tus exam; e c evaluation	Psychiatric diagnostic interview examination includes a history; mental status exam; evaluation and assessment of physiological phenomena (including co-morbidity between behavioral and physical health care issues); psychiatric diagnostic evaluation (including assessing for co-occurring disorders and the development of a differential diagnosts); screening and/or assessment of any with drawel symptoms for the individual with substance related diagnoses; assessment of the	ological phing disorded	ers and	ena (inclidated)	nding co-n elopment	iorbidity of a
Definition	appropriateness of initiating or continuing services; telemedicine) and may include communication with studies.	itinuing se	rvices; and with a	and a di family a	spositic nd othe	on. The	se are comp es and the c	appropriate angles of initiating or continuing services; and a disposition. These are completed by face-to-face evaluation of the individual (which may include the use of telemedicine) and may include communication with family and other sources and the ordering and medical interpretation of laboratory or other medical diagnostic studies.	the individ	is, ass lual (wl ory or c	hich may	r include the	e use of ostic
Admission Criteria	 Individual has a known or suspected mental illness or a substance-related disorder Individual is in need of annual assessment and re-authorization of service array; or Individual has need of an assessment due to a change in clinical/functional status. 	ected men assessmer ssment du	ital illne rand ra e to a c	ss or a se-author hange in	substar rization n clinica	nce-rela of serv al/function	ted disorder ice array; or onal status.	 Individual has a known or suspected mental illness or a substance-related disorder and has recently entered the service system; or Individual is in need of annual assessment and re-authorization of service array; or Individual has need of an assessment due to a change in clinical/functional status. 	ce system	or i			
Continuing Stay Criteria	Individual's situation/functioning has changed in such a way that previous assessments are outdated.	as change	d in suc	h a way	, that pr	evious	assessment	ts are outdated.					
Discharge Criteria	An adequate continuing care plan has been established; and one or i Individual has withdrawn or been discharged from service; or Individual no longer demonstrates need for additional assess	lan has be wn or beer emonstrate	en esta discha s need	ublished; and one or more riged from service; or for additional assessment.	; and o om serv itional a	ne or n ice; or assessm	blished; and one or more of the following: rged from service; or for additional assessment.	following:					
Service Exclusions	Assertive Community Treatment												
Required Components	1. When providing diagnostic services to individuals who are deaf, deaf-blind, or hard of hea consultation with a qualified professional as approved by DBHDD Office of Deaf Services.	vices to incofessional	dividual as app	s who a	re deaf y DBHI	, deaf-b)D Offic	olind, or hard e of Deaf So	When providing diagnostic services to individuals who are deaf, deaf-blind, or hard of hearing, diagnosticians shall demonstrate training, supervision, and/or consultation with a qualified professional as approved by DBHDD Office of Deaf Services.	monstrate	trainir	ig, supei	vision, and	//or
Staffing Requirements	The only U3 practitioners who can provide Diagnostic Assessment are an LCSW, LMFT, or LPC.	provide D	iagnost	ic Asse	ssment	are an	LCSW, LMF	=T, or LPC.					

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agnostic	Diagnostic Assessment												
Billing and	1. 90791 is used when an initial evaluation is provided by a non-physician. 2. 90792 is used when an initial evaluation is provided by a physician, PA,	evaluation evaluation	is prov	ided by ided by	a non-r a physi	ohysicie cian, P,	an. A, or APRN	non-physician. physician, PA, or APRN. This 90792 intervention content would include all general behavioral health	nclude a	II genera	al behavio	ral health	
Requirements	assessment as well as medical assessment/physical exam beyond mental status as appropriate. 3. If a Medicaid claim for this service denies for a Procedure-to-Procedure edit, a modifier (59) can	al assessn rvice denie	nent/ph; ss for a l	ysical e. Procedu	xam be) ure-to-P	nond m	ental status re edit, a m	assessment as well as medical assessment/physical exam beyond mental status as appropriate. 3. If a Medicaid claim for this service denies for a Procedure-to-Procedure edit, a modifier (59) can be added to the claim and resubmitted to the MMIS for payment.	l resubm	itted to	the MMIS	for payment.	C
Service	1. This service may be provided	via teleme	dicine t	o any ir	dividua	who c	onsents to	1. This service may be provided via telemedicine to any individual who consents to this modality. This consent should be documented in the individual's record. The	umentec	I in the ii	ndividual's	s record. The	as
Accessibility	use of telemedicine should <u>not</u> be driven by the practitioner's/agency's convenience or preference.	<u>ot</u> be driven	by the	practition	oner's/a	gency's	s convenier	ce or preference.					е
Additional Medicaid Requirements	The daily maximum for Diagnostic Assessment (Psychiatric diagnostic case for the principle diagnostician to call in a phy	ic Assessm diagnosticia	nent (Ps an to ca	ychiatri II in a pl	c Diagn hysician	ostic In for an	terview) for assessmer	The daily maximum for Diagnostic Assessment (Psychiatric Diagnostic Interview) for adults is 2 units. Two units should be utilized only if it is necessary in a complex diagnostician to call in a physician for an assessment of the individual to corroborate or verify the correct diagnosis.	ized only the corr	r if it is n ect diagı	ecessary nosis.	in a complex	1:16-c
	•												v-0
ımily Outp	Family Outpatient Services: Family Counseling	Sounselii	DG										30
Transaction Code	Code Detail	Code	Mod 1	Mod 2	Mod 3	Mod 4	Rate	Code Detail Code		Mod Mod 1 2	Mod 3	Mod Rate 4	88-E
	Practitioner Level 2, In-Clinic	H0004	HS	U2	90		\$38.97	Practitioner Level 2, Out-of-Clinic H0004	04 HS) U2	U2	\$46.76	LF
	Practitioner Level 3, In-Clinic	H0004	HS	n3	90		\$30.01	Practitioner Level 3, Out-of-Clinic H0004	04 HS) U3	U2	\$36.68	₹
	Practitioner Level 4, In-Clinic	H0004	HS	N4	90		\$20.30	Practitioner Level 4, Out-of-Clinic H0004	04 HS) U4	U2	\$24.36	[
Family – BH	Practitioner Level 5, In-Clinic	H0004	HS	S N	90		\$15.13	Practitioner Level 5, Out-of-Clinic H0004	04 HS	90 9	U2	\$18.15	Οo
counseling/	Practitioner Level 2, Via							Practitioner Level 4, Via interactive					cu
therapy (w/o	interactive audio and video	H0004	GT	SH.	U2		\$38.97	audio and video telecommunication H0004	04 GT	오	7	\$20.30	m
client present)	telecommunication systems							systems					en
	Practitioner Level 3, Via							Practitioner Level 5, Via interactive					t 4
	interactive audio and video	H0004	GT	E S H	U3		\$30.01	audio and video telecommunication H0004	04 GT	오	C2	\$15.13	48
	telecommunication systems							systems					3-7
	Practitioner Level 2, In-Clinic	H0004	HR	U2	90		\$38.97	Practitioner Level 2, Out-of-Clinic H0004	04 HR	l U2	U7	\$46.76	73
	Practitioner Level 3 In-Clinic	HOOOA	H	211	911		\$30.01	Practitionar Layel 3 Out-of-Clinic HOOO	HUUUT HB	2	117	\$36.68	

Family Outp	Family Outpatient Services: Family Counseling	Sounseli	DG										
Transaction	Code Detail	Code	Mod	Mod	Mod	Mod	Rate	Code Detail	Code	роМ	роМ	Mod Mod	d Rate
Code			1	2	3	4				1	2	3 4	
	Practitioner Level 2, In-Clinic	H0004	HS	U2	90		\$38.97	Practitioner Level 2, Out-of-Clinic	H0004	SH	N2	U2	\$46.76
	Practitioner Level 3, In-Clinic	H0004	HS	U3	90		\$30.01	Practitioner Level 3, Out-of-Clinic	H0004	SH	EN	U2	\$36.68
	Practitioner Level 4, In-Clinic	H0004	HS	U4	90		\$20.30	Practitioner Level 4, Out-of-Clinic	H0004	SH	hO	U2	\$24.36
Family – BH	Practitioner Level 5, In-Clinic	H0004	HS	O5	90		\$15.13	Practitioner Level 5, Out-of-Clinic	H0004	SH	SN	U2	\$18.15
counseling/	Practitioner Level 2, Via							Practitioner Level 4, Via interactive					
therapy (<u>w/o</u>	interactive audio and video	H0004	GT	SH.	U2		\$38.97	audio and video telecommunication	H0004	GT	옷	4	\$20.30
client present)	telecommunication systems							systems					
	Practitioner Level 3, Via							Practitioner Level 5, Via interactive					
	interactive audio and video	H0004	GT	SH	N3		\$30.01	audio and video telecommunication	H0004	GT	SH	O5	\$15.13
	telecommunication systems							systems					
	Practitioner Level 2, In-Clinic	H0004	HR	U2	90		\$38.97	Practitioner Level 2, Out-of-Clinic	H0004	HR	U2	U2	\$46.76
	Practitioner Level 3, In-Clinic	H0004	Ή	EN	90		\$30.01	Practitioner Level 3, Out-of-Clinic	H0004	HR	EN	10	\$36.68
	Practitioner Level 4, In-Clinic	H0004	Ή	U4	90		\$20.30	Practitioner Level 4, Out-of-Clinic	H0004	HR	PN	10	\$24.36
Family – BH	Practitioner Level 5, In-Clinic	H0004	HR	U5	90		\$15.13	Practitioner Level 5, Out-of-Clinic	H0004	HR	SU	U2	\$18.15
counseling/	Practitioner Level 2, Via							Practitioner Level 4, Via interactive					
therapy (<u>with</u>	interactive audio and video	H0004	GT	품	U2		\$38.97	audio and video telecommunication	H0004	GT	光	4	\$20.30
client present)	telecommunication systems							systems					
	Practitioner Level 3, Via							Practitioner Level 5, Via interactive					
	interactive audio and video	H0004	GT	壬	N3		\$30.01	audio and video telecommunication	H0004	GT	壬	U5	\$15.13
	telecommunication systems							systems					
	Practitioner Level 2, In-Clinic	90846	U2	90			\$38.97	Practitioner Level 2, Out-of-Clinic	90846	U2	U2		\$46.76
Family Psycho-	Practitioner Level 3, In-Clinic	90846	U3	90			\$30.01	Practitioner Level 3, Out-of-Clinic	90846	EN	ZN		\$36.68
therapy w/o the	Practitioner Level 4, In-Clinic	90846	U4	90			\$20.30	Practitioner Level 4, Out-of-Clinic	90846	D4	ZN		\$24.36
patient present	Practitioner Level 5, In-Clinic	90846	U5	90			\$15.13	Practitioner Level 5, Out-of-Clinic	90846	N2	U7		\$18.15
(appropriate	Practitioner Level 2, Via							Practitioner Level 4, Via interactive					
license required)	interactive audio and video	90846	GT	U2			\$38.97	audio and video telecommunication	90846	GT	4		\$20.30
	telecommunication systems							systems					

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ramily Outp	ramily outpatient services: ramily counseling	ounsell	වු						_			
	Practitioner Level 3, Via						Practitioner Level 5, Via interactive					
	interactive audio and video	90846	GT	N3		\$30.01	audio and video telecommunication	90846	GT	C2	\$15.13	13
	telecommunication systems						systems					
	Practitioner Level 2, In-Clinic	90847	U2	90		\$38.97	Practitioner Level 2, Out-of-Clinic	90847	U2	U2	\$46.76	
Conjoint	Practitioner Level 3, In-Clinic	90847	EN	90		\$30.01	Practitioner Level 3, Out-of-Clinic	90847	N3	107	\$36.68	
Family Psycho-	Practitioner Level 4, In-Clinic	90847	D4	90		\$20.30	Practitioner Level 4, Out-of-Clinic	90847	V4	107	\$24.36	
therapy w/ the	Practitioner Level 5, In-Clinic	90847	SN	90		\$15.13	Practitioner Level 5, Out-of-Clinic	90847	OS	U2	\$18.15	
patient presents	Practitioner Level 2, Via						Practitioner Level 4, Via interactive					16
a portion or the	interactive audio and video	90847	GT	N2		\$38.97	audio and video telecommunication	90847	GT	40	\$20.30	
entire session	telecommunication systems						systems					V-(
(appropriate	Practitioner Level 3, Via						Practitioner Level 5, Via interactive					03
license required)	interactive audio and video	90847	GT	U3		\$30.01	audio and video telecommunication	90847	GI	N2	\$15.13	
	telecommunication systems						systems					8-
Unit Value	15 minutes						Utilization Criteria	TBD				EL
	A therapeutic intervention or couclinician or practitioner. Services specified in the Individualized Realways provided for the benefit or	inseling ser are directe scovery Pla	vice she she towar	own to be rd achieve focus of fa	successful ment of spe mily couns	with identifiescific goals deling is the fa	A therapeutic intervention or counseling service shown to be successful with identified family populations, diagnoses and service needs, provided by a qualified clinician or practitioner. Services are directed toward achievement of specific goals defined with/by the individual and targeted to the individual-identified family and specified in the Individualized Recovery Plan. The focus of family counseling is the family or subsystems within the family, e.g. the parental couple. The service is always provided for the benefit of the individual and may or may not include the individual control.	d service geted to t y, e.g. the	needs, the indivi-	provided by a qu ridual-identified al couple. The s	ualified family and service is	R Doo
		2	; ;	: ; (Sil.	٠٠٠٠ الم				5			<u>Cur</u>
	Family counseling provides systematic interactions betwee development, enhancement or maintenance of functioning	ematic inter aintenance	ractions e of fun	between t	he identifie the identifi	d individual, ed individual	Family counseling provides systematic interactions between the identified individual, staff and the individual's identified family members directed toward the restoration, development, enhancement or maintenance of functioning of the identified individual/family unit. This includes support of the family and specific therapeutic	amily me f the fami	mbers o	lirected toward to	he restorati itic	ment ຮົ
	interventions/activities to enhanc	e family ro	les, rela	itionships,	communica	ation and fur	interventions/activities to enhance family roles, relationships, communication and functioning that promote the recovery of the individual. Specific goals/issues to be	of the indi	vidual.	Specific goals/is	senes to be	44
Service	addressed though these services may include the restoration, development, enhancement or maintenance of:	s may inclu	de the I	estoration	, developm	ent, enhanc	ement or maintenance of:					8-7
Definition												73
		isms; יפוויאפיר										
	Adaptive beliavious and skills, Internersonal skills:	ovillo,										Fil
		ne Jule. an	~									ed
	6. The family's understanding of mental illness and	ding of mer	o otal illne otal	ss and sul	ostance rel	ated disorde	substance related disorders, the steps necessary to facilitate recovery, and methods of intervention,	recovery,	and me	thods of interve	ntion,	11/
	interaction and mutual support the family can use to assist their family member.	support the	tamıly	can use to	assist thei	r tamıly men	ıber.					/29/
	Best practices such as Multi-Sys	temic Fam	ily Ther	apy, Multic	limensiona	Family The	Best practices such as Multi-Systemic Family Therapy, Multidimensional Family Therapy, Behavioral Family Therapy, Functional Family Therapy or others appropriate	ınctional	Family	Therapy or othe	rs appropri	
	for the family and issues to be addressed should be utilized in the provision of this service.	ddressed s	ponld b	e utilized ir	the provis	ion of this se	ervice.					
	1. Individual must have a menta	Il illness an	d/or suk	stance-rel	ated disorc	ler diagnosis	1. Individual must have a mental illness and/or substance-related disorder diagnosis that is at least destabilizing (markedly interferes with the ability to carry out	dly interfe	eres wit	n the ability to ca	arry out	Pa
Admission	activities of daily living of places offices in dailget) of distressing (causes filerial anguistro) suffering), and	ces officers of	n dang	ar) or distre	essing (cau	vices in an o	anguish of suffering), and artostiont milion: and					
Criteria	3. Individual's assessment indig	ates needs	that m	av be supp	orted by th	erapeutic int	 Individual's assessment indicates needs that may be supported by therapeutic intervention shown to be successful with identified family populations and individual's 	ith identif	ied fam	Ilv populations a	nd individu	
	diagnoses.					- -						
Continuing Stay		admission (criteria a	as articulat	ed above;	and	:					of 6
Criteria	2. Progress notes document pro	ogress relat	ive to g	oals identi	ied in the l	ndividualized	Progress notes document progress relative to goals identified in the Individualized Recovery Plan, but all treatment/support goals have not yet been achieved	upport go	als hav	e not yet been a	chieved.	527
Discharge	1. An adequate continuing care plan has been established; and one or more of the following:	plan has b	een est	ablished; a	nd one or	more of the	following:					7
Criteria												1

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Family Outp	Family Outpatient Services: Family Counseling 2. Goals of the Individualized Recovery Plan have been substantially met; or 3. Individual requests discharge and individual is not in imminent danger of harm to self or others; or 4. Transfer to another service is warranted by change in individual's condition; or	
Service	5. Individual requires more intensive services. ACT	Case
Exclusions		e 1
Clinical Exclusions	 Severity of behavioral health impairment precludes provision of services. Severity of cognitive impairment precludes provision of services in this level of care. Severity of cognitive impairment precludes provision of services in this level of care. There is a lack of social support systems such that a more intensive level of service is needed. This service is not intended to supplant other services such as IID/IDD Personal and Family Support or any day services where the individual may more appropriately receive these services with staff in various community settings. Individuals with the following conditions are excluded from admission unless there is clearly documented evidence of a psychiatric condition overlaying the diagnosis: Developmental Disability, Autism, Neurocognitive Disorder and Traumatic Brain Injury. 	L:16-cv-03088-E
Required	1. The treatment/recovery orientation, modality and goals must be specified and agreed upon by the individual. 2. Couples counseling is included under this service code if the counseling is directed toward the identified individual and his/her goal attainment as identified in the	LR
Components	Individualized Recovery Plan. 3. The Individualized Recovery Plan for the individual includes goals and objectives specific to the individual-identified family for whom the service is being provided.	Do
Clinical Operations	Models of best practice delivery may include (as clinically appropriate) Multidimensional Family Therapy, Behavioral Family Therapy, Functional Family Therapy, and others as appropriate the family and issues to be addressed.	cume
	1. Services may not exceed 8 Billable units (combined Family Counseling and Family Therapy) in a single day. If clinical need indicates this level of intensity, other	ent 4
	2. To promote access, providers may use Telemedicine as a tool to provide direct interventions to individuals for whom English is not their first language. Examples of this include:	448-7
Service	• the use of one-to-one service intervention via Telemedicine, connecting the individual to a practitioner who speaks the individual's language versus use of intermeters: and/or	3
Accessibility	 the use of an interpreter via Telemedicine to support the practitioner in delivering the identified service. 	Filed
	Telemedicine may only be utilized when delivering this service to an individual for whom English is not their first language. The individual must consent to the use of this modality. This consent should be documented in the individual's record. The use of telemedicine should <u>not</u> be driven by the practitioner's/agency's convenience or preference.	11/29/
	If there are multiple family members in the Family Counseling session who are enrolled individuals for whom the focus of treatment is related to goals on their IRPs, the	23
Documentation Requirements	Tollowing applies. 1. Document the family session in the chart of each individual for whom the treatment is related to a specific goal on the individual's IRP. 2. Charge the Family Counseling session units to one of the individuals.	Pag
		je 14
Billing & Reporting Requirements	 If a Medicaid claim for this service denies for a Procedure-to-Procedure edit, a modifier (59) can be added to the claim and resubmitted to the MMIS for payment. When Telemedicine technology is utilized for the provision of this service in accordance with the allowance in the Service Accessibility section of this definition, the code cited in the Code Detail above with the appropriate GT modifier shall be utilized in documentation and claims submission. 	4 of 627

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		Ca	se 1:	16- c	v-03	088-ELR	Docui	ne	ent 448-73	Filed	111/	29/	23	Pa	ge	14!	5 0	f 62	27
	Rate	\$20.30	\$15.13	\$24.36	\$18.15	20.30	15.13		specific ay dentified unit.	lge of						ry out		pue	2
	Mod 4								ment of ions me ment of me ion the i	cnowlec				; ;	,	y to car		ations	,
	Mod 3	90	90	U7	U7	₽	US		chiever terventi betwee dividual	skills, k				,	בו א בו	e ability		אוומטט /	7 7 7
	Mod 2	40	US	40	U5		光		ward a bugh in actions iffed inc	/ention				40	lo spoi	with th		d family	2
	Mod 1	壬	壬	壬	壬	GT	GT		ected to te: althotic inter tic inter ne ident of the ir	se pre				400	ום ום וח	terferes		dentifie	2
	Code	H2014	H2014	H2014	H2014	H2014	H2014	TBD	Services are directed toward achievement of specific acovery Plan (note: although interventions may rovides systematic interactions between the identified functioning of the identified individual/family unit. ote the recovery of the individual. Specific paintenance of:	ent, relap				200	overy, a	ırkedly in		i din with i	
	Code Detail	Practitioner Level 4, In-Clinic, with client present	Practitioner Level 5, In-Clinic, with client present	Practitioner Level 4, Out-of-Clinic, with client present	Practitioner Level 5, Out-of-Clinic, with client present	Practitioner Level 4, Via interactive audio and video telecommunication systems, with client present	Practitioner Level 5, Via interactive audio and video telecommunication systems, with client present	Utilization Criteria		sacs to be addressed income first set most may make the restoration, development, or manner and self-management knowledge and skills, knowledge of management, relapse prevention skills, knowledge of madications and side offerers and matrix timelity and included the madications and side offerers and matrix timelity and included the madication of presents and side offerers and matrix timelity and included the matrix of the matrix timelity and included the matrix of the matrix timelity and the matrix timelit	פעוכמוטו אס פוססטוססט),			on otalions of monocone and other	rie family's understanding of mental miness and substance related disorders, the steps necessary to racintate recovery, and membes of intervention, nteraction and mutual support the family can use to assist their family member.	Individual must have a mental illness and/or substance-related disorder diagnosis that is at least destabilizing (markedly interferes with the ability to carry out	activities of daily living or places others in danger) or distressing (causes mental anguish or suffering); and	ie provision of services in an outpatient milieu; and e supported by a therapeutic intervention shown to be successful with identified family populations and	
	Rate	\$20.30	\$15.13	\$24.36	\$18.15	20.30	15.13		oppulations, d family and sp : always be th toward the en activities to er	(e.g. sympton	וו ומצווות			ניים ליים ליים	ateu disolder ir family memt	disorder diag	ig (causes me	ot services in	ישטיטיי א ניול
	Mod 4								family properties of must rected to pecific a	d skills				000	iice iei ist thei	related	tressin	ovision	2
	Mod 3	90	90	10	10	Q 4	U5		ntified Inal-ide	dge and				4.04.0	substa to ass	stance-	n) or dis	the pri	3
	Mod 2	4	U5	4 0	U5	SH.	SH.		vith ide individ of individ of inte of interest of int	conde knowlec	skills;			and	ss allu can use	or subs	dangel	reclude	<u>.</u>
	Mod 1	R F	R S	HS.	HS.	GT	GT		essful verses to the to the leftciary ed familias well as services	ement P	ctional			it skills;	family	ss and/	hers in	s not p	; 5 5 5
aining	Code	H2014	H2014	H2014	H2014	H2014	H2014		be succ I targete nary ber s identifie mily, as o	F-manag	icing fun	ns; ills;		nagemer of mon	port the	ntal illne	olaces ot	ning doe dicates r	
Family Outpatient Services: Family Training	Code Detail	Practitioner Level 4, In-Clinic, without client present	Practitioner Level 5, In-Clinic, without client present	Practitioner Level 4, Out-of-Clinic, without client present	Practitioner Level 5, Out-of-Clinic, without client present	Practitioner Level 4, Via interactive audio and video telecommunication systems, without client present	Practitioner Level 5, Via interactive audio and video telecommunication systems, without client present	15 minutes	A therapeutic interaction shown to be successful with identified family populations, diagnoses and service needs. goals defined by the individual and targeted to the individual-identified family and specified in the Individualized R involve the family, the focus or primary beneficiary of intervention must always be the individual). Family training principle, staff and the individual's identified family members directed toward the enhancement or maintenance of This may include support of the family, as well as training and specific activities to enhance functioning that promotorals/issues to be addressed though these services may include the restoration development enhancement or maintenance.	1. Illness and medication self-management knowledg		 Healthy coping mechanisms; Adaptive behaviors and skills; 			-	1. Individual must have a me	_	 Individual's level of functioning does not preclude the provision of services in an outpatient milleu; and Individual's assessment indicates needs that may be supported by a therape fit intervention shown to 	
Family Outpo	Transaction Code				Family Skills	Development		Unit Value			Definition						Admission	Criteria	

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	Case	1:10	6-cv-0308	8-ELR	Docur	ment 448-	73 Fil	led 11/2	9/23 Page	146 of 62
ci	 An adequate continuing care plan has been established; and one or more or the rollowing: Goals of the Individualized Recovery Plan have been substantially met; or Individual requests discharge and individual is not in imminent danger of harm to self or others; or Transfer to another service is warranted by change in individual's condition; or Individual requires more intensive services. 	ACT	 Severity of behavioral health impairment precludes provision of services. Severity of cognitive impairment precludes provision of services in this level of care. There is a lack of social support systems such that a more intensive level of service is needed. There is no outlook for improvement with this particular service. 	 Inis service is not intended to supplant other services such as Personal and Family Support or any day services where the individual may more appropriately receive these services with staff in various community settings. Individuals with the following conditions are excluded from admission unless there is clearly documented evidence of a psychiatric condition overlaying the diagnosis: Developmental Disability, Autism, Neurocognitive Disorder and Traumatic Brain Injury. 	The treatment orientation, modality and goals must be specified and agreed upon by the individual. The Individualized Recovery Plan for the individual includes goals and objectives specific to the individual-identified family for whom the service is being provided.	 Services may not exceed 8 Billable units (combined Family Counseling and Family Therapy) in a single day. If clinical need indicates this level of intensity, other services may need to be considered for authorization. To promote access, providers may use Telemedicine as a tool to provide direct interventions to individuals for whom English is not their first language. Examples of this include: 	 the use of one-to-one service intervention via Telemedicine, connecting the individual to a practitioner who speaks the individual's language versus use of interpreters; and/or the use of an interpreter via Telemedicine to support the practitioner in delivering the identified service. 	Telemedicine may only be utilized when delivering this service to an individual for whom English is not their first language. The individual must consent to the use of this modality. This consent should be documented in the individual's record. The use of telemedicine should not be driven by the practitioner's/agency's convenience or preference.	If there are multiple family members in the Family Training session who are enrolled individuals for whom the focus of treatment in the group is related to goals on their IRPs, the following applies: 1. Document the family session in the chart of each individual for whom the treatment/support is related to a specific goal on the individuals. 2. Charge the Family Training session units to <u>one</u> of the individuals. 3. Indicate "NC" (No Charge) on the documentation for the other individual(s) in the family session and have the note reflect that the charges for the session.	When Telemedicine technology is utilized for the provision of this service in accordance with the appropriate GT modifier shall be utilized in documentation and claims submission.
Continuing Stay Criteria	Discharge Criteria	Service Exclusions	Olinical 	Exclusions	Required Components		Service Accessibility		Documentation Requirements	Billing & Reporting Requirements

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Group Outpatient Services: Group Counseling		OII DOII D	S)		H										С
Code Detail Code			Mod 1	Mod 2	y Mod 3	Mod 4	Rate	Code Detail	Code	Mod 1	Mod 2	Mod 3	Mod 4	Rate	ase
Practitioner Level 2, In-Clinic H0004 HQ		ヹ	ď	N2	90		\$8.50	Practitioner Level 2, Out-of-Clinic, Multi-family group, w/ client present	H0004	오	光	N2	U2	\$10.39	1:16
Practitioner Level 3, In-Clinic H0004 HQ		오		U3	90		\$6.60	Practitioner Level 3, Out-of-Clinic, Multi-family group, w/ client present	H0004	오	뚶	U3	10 10	\$8.25	i-cv-(
Practitioner Level 4, In-Clinic H0004 HQ		웃	l	40	90		\$4.43	Practitioner Level 4, Out-of-Clinic, Multi-family group, w/ client present	H0004	오	光	40	U2	\$5.41	0308
Practitioner Level 5, In-Clinic H0004 HQ		免		U5	90		\$3.30	Practitioner Level 5, Out-of-Clinic, Multi-family group, w/ client present	H0004	얼	HR	N2	U2	\$4.03	8-EL
Practitioner Level 2, Out-of-Clinic H0004 HQ		욧	1	U2	U7		\$10.39	Practitioner Level 2, In-Clinic, Multi-family group, without client present	H0004	욧	Я	U2	90	\$8.50	R D
Practitioner Level 3, Out-of-Clinic H0004 HQ		HQ		U3	U7		\$8.25	Practitioner Level 3, In-Clinic, Multi-family group, without client present	H0004	НQ	HS	U3	90	\$6.60	ocume
Practitioner Level 4, Out-of-Clinic H0004 HQ		Б		U4	U7		\$5.41	Practitioner Level 4, In-Clinic, Multi-family group, without client present	H0004	ВÃ	HS	U4	90	\$4.43	nt 448
Practitioner Level 5, Out-of-Clinic H0004 HQ		бH		US	U7		\$4.03	Practitioner Level 5, In-Clinic, Multi-family group, without client present	H0004	욧	НS	US	90	\$3.30	
Practitioner Level 2, In-Clinic, Multi-family group, with client present	БĀ			光	U2	9N	\$8.50	Practitioner Level 2, Out-of-Clinic, Multi-family group, without client present	H0004	В́	HS	U2	U7	\$10.39	Filed 11
Practitioner Level 3, In-Clinic, Multi-family group, with client present	М			光	U3	U6	\$6.60	Practitioner Level 3, Out-of-Clinic, Multi-family group, w/o client present	H0004	Ä	HS	U3	U7	\$8.25	
Practitioner Level 4, In-Clinic, Multi-family group, w/ client present	HQ		l l	¥	104 104	N6	\$4.43	Practitioner Level 4, Out-of-Clinic, Multi-family group, w/o client present	H0004	Ř	HS	U4	U7	\$5.41	•
Practitioner Level 5, In-Clinic, Multi-family group, w/ client present		Й		HR	US	90	\$3.30	Practitioner Level 5, Out-of-Clinic, Multi-family group, w/o client present	H0004	Ř	HS	US	U7	\$4.03	ge 147
Practitioner Level 2, In-Clinic 90853 U2	H	U2	-	90			\$8.50	Practitioner Level 2, Out-of-Clinic	90853	N2	U2			\$10.39	UI
90853	\vdash	N3	-	90			\$6.60	Practitioner Level 3, Out-of-Clinic	90853	N3	LO			\$8.25	02
90853		4	-	90			\$4.43	Practitioner Level 4, Out-of-Clinic	90853	2 5	10			\$5.41	• •
Practitioner Level 5, In-Clinic 90853 U5	-	ဌ	1	ηρ			\$3.30	Practitioner Level 5, Out-of-Clinic	90853	CO	0/			\$4.03	

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license required)		
Unit Value	15 minutes TBD TBD	
	A therapeutic intervention or counseling service shown to be successful with identified populations, diagnoses and service needs, provided in a group format by a qualified clinician or practitioner. Services are directed toward achievement of specific goals defined by the individual and specified in the Individualized Recovery Plan. Services may address goals/issues such as promoting recovery, and the restoration, development, enhancement or maintenance of:	С
Service Definition	Cognitive processing skills; Healthy coping mechanisms;	ase 1
		1:1
	4. Interpersonal skills; and	.6-0
		CV-
-	1. Individual must have a mental illness/substance-related disorder diagnosis that is at least destabilizing (markedly interferes with the ability to carry out activities of	03
Admission Criteria	daily living or places others in danger) or distressing (causes mental anguish or suttering); and 2. The individual's level of functioning does not preclude the provision of services in an outpatient milieu: and	880
	3. The individual's recovery goal/s which are to be addressed by this service must be conducive to response by a group milieu.	3-E
Continuing Stay		LF
Criteria	2. Individual demonstrates documented progress relative to goals identified in the Individualized Recovery Plan, but treatment goals have not yet been achieved.	?
	An adequate continuing care plan has been established; and one or more of the following:	С
Dischargo	Goals of the Individualized Recovery Plan have been substantially met; or	00
Criteria	ers; or	cui
סווסווס	Transfer to another service/level of care is warranted by change in individual's condition; or	me
	Individual requires more intensive services.	ent
Service Exclusions	See Required Components, items 2 and 3 below.	448
	Severity of behavioral health impairment precludes provision of services.	3-7
	vel of care.	3
Clinical	There is a lack of social support systems such that a n	
Exclusions	This service is not intended to supplant other services	File
		ed
	diagnosis: Developmental Disability, Autism, Neurocognitive Disorder and Traumatic Brain Injury.	11/
	1. The recovery orientation, modality and goals must be specified and agreed upon by the individual.	29/
		/23
Required	in the record and may be subject to scrutiny by the Administrative Services organization. Exceptions in offering group outpatient services external to day services	}
Components	urvivor groups, perpetrator groups, and sexual abuse survivor groups. When an exception is	Р
	clinically justified, services must not duplicate day services activities.	age
Staffina		2 1
Requirements	Maximum face-to-face ratio cannot be more than 10 individuals to 1 direct service staff based on average group attendance.	48
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participants for a particular gro	up, worki	ng with t	he grou	p to est	ablish r	necessan	participants for a particular group, working with the group to establish necessary group norms and goals, and understanding and managing group dynamics and processes.	understanding an	d mar	aging (roup dyn	dynamics and	(
If a Medicaid claim for this ser	vice denie	s for a P	rocedu	re-to-Pr	ocedur	e edit, a r	If a Medicaid claim for this service denies for a Procedure-to-Procedure edit, a modifier (59) can be added to the claim and resubmitted to the MMIS for payment.	aim and resu	ubmitte	ed to th	e MMIS fo	or payment.	Case 1
daily maximum within a CSU for combined Group Training/Counseling is 4 units/day.	r combine	d Group	Trainin	g/Coun	seling is	s 4 units/	day.						.:16-cv
nt Services: Group Train	Training												-0308
e Detail	Code	Mod 1	Mod 2	Mod 3	Mod 4	Rate	Code Detail	Code 1	Mod 1	Mod 2	Mod Mod 3 4	nd Rate	8-ELF
titioner Level 4, In-Clinic	H2014	9	U4	90		\$4.43	Practitioner Level 4, Out-of-Clinic, with client present	H2014 H	9	뚶	U4 U7	\$5.41	٦ I
titioner Level 5, In-Clinic	H2014	오	U5	90		\$3.30	Practitioner Level 5, Out-of-Clinic, with client present	H2014 H	오	뚠	US U7	\$4.03	Docu
titioner Level 4, Out-of-Clinic	H2014	9	U4	U7		\$5.41	Practitioner Level 4, In-Clinic, without client present	H2014 H	오	와 오	U4 N6	\$4.43	ımen
titioner Level 5, Out-of-Clinic	H2014	9	U5	U7		\$4.03	Practitioner Level 5, In-Clinic, without client present	H2014 H	9	R SH	US U6	\$3.30	t 448
titioner Level 4, In-Clinic, with t present	H2014	9	壬	U4	90	\$4.43	Practitioner Level 4, Out-of-Clinic, without client present	H2014 H	9	R.	U4 U7	\$5.41	8-73
titioner Level 5, In-Clinic, with t present	H2014	9	壬	U5	90	\$3.30	Practitioner Level 5, Out-of-Clinic, without client present	H2014 H	오	R SH	US U7	\$4.03	Fi
ninutes							Maximum Daily Units	20 units					lec
erapeutic interaction shown to be successful with identificated by the individual and specified in the Individualized Relationals of	e success ed in the l	sful with ndividua	identifie lized Re	d popul	ations, / Plan.	diagnose Services	erapeutic interaction shown to be successful with identified populations, diagnoses and service needs. Services are directed toward achievement of specific goals ned by the individual and specified in the Individualized Resiliency Plan. Services may address goals/issues such as promoting recovery, and the restoration,	directed tow promoting re	ard ad	chieven y, and	nent of spi the restora	ecific goals ation,	11/2
Illness and medication self-ma	ınagemen	t knowle	dge and	skills (e.g., sy	mptom r	Johnson, emancement of maintenance of. Illness and medication self-management knowledge and skills (e.g., symptom management, behavioral management, relapse prevention skills, knowledge of	nt, relapse p	orever	ition ski	lls, knowl	edge of	9/23
medications and side effects, and motivational/skill development in taking medication as prescribed); Problem solving skills;	and motiv	ational/s	KIII deve	elopmer	it in tak	ing medic	cation as prescribed);						
Healthy coping mechanisms; Adaptive skills;													Page
Interpersonal skills; Daily living skills:													149
Resource management skills;	9	9	-		9	9		9 6 1		, ,	1		of
knowledge regarding mental lilness, substance related disorders and other relevant top. Skills necessary to access and build community resources and natural support systems.	iness, sur I build cor	nmunity	related	disorde ses and	s and c natural	support :	disorders and other relevant topics that assist in meeting the youth's and ramily's needs; and ces and natural support systems.	e yourn s an	d ram	iy s nee	eds; and		627
, , , , , , , , , , , , , , , , , , , ,		,)										,

Practitioner Level 4, In-Clinic H2014 H20 Mod Mod Mod Rate Code Detail Code Mod	Group Outp	Group Outpatient Services: Group Training	guir												
Practitioner Level 4, In-Clinic H2014 HQ Practitioner Level 5, In-Clinic H2014 HQ Practitioner Level 5, Out-of-Clinic H2014 HQ Practitioner Level 5, Out-of-Clinic H2014 HQ client present Practitioner Level 5, In-Clinic, with Client present 15 minutes A therapeutic interaction shown to be successful with defined by the individual and specified in the Individual development, enhancement or maintenance of: 1. Illness and medication self-management knowle medications and side effects, and motivational/s. 2. Problem solving skills; 3. Healthy coping mechanisms; 4. Adaptive skills; 6. Daily living skills; 7. Resource management skills; 8. Knowledge regarding mental illness, substance of the contraction of the c	Transaction Code	Code Detail	Code	Mod 1	Mod 2			Rate	Code Detail	Code	Mod 1	Mod 2	Mod 3	Mod 4	Rate
Practitioner Level 5, In-Clinic Practitioner Level 4, Out-of-Clinic Practitioner Level 4, Out-of-Clinic Practitioner Level 5, Out-of-Clinic Practitioner Level 5, In-Clinic, with Client present Practitioner Level 5, In-Clinic, with Client present 15 minutes A therapeutic interaction shown to be successful with defined by the individual and specified in the Individual development, enhancement or maintenance of: 1. Illness and medication self-management knowle medications and side effects, and motivational/s. 2. Problem solving skills; 3. Healthy coping mechanisms; 4. Adaptive skills; 5. Interpersonal skills; 6. Daily living skills; 7. Resource management skills; 8. Knowledge regarding mental illness, substance of the substance of		Practitioner Level 4, In-Clinic	H2014	9	40	90		\$4.43	Practitioner Level 4, Out-of-Clinic, with client present	H2014	오	뚶	40	10	\$5.41
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Practitioner Level 4, In-Clinic, with client present Practitioner Level 5, In-Clinic, with client present 15 minutes A therapeutic interaction shown to be successful with defined by the individual and specified in the Individual development, enhancement or maintenance of: 1. Illness and medication self-management knowle medications and side effects, and motivationally. 2. Problem solving skills; 3. Healthy coping mechanisms; 4. Adaptive skills; 5. Interpersonal skills; 6. Daily living skills; 7. Resource management skills; 8. Knowledge regarding mental illness, substance of the still of the	Development	Practitioner Level 5, Out-of-Clinic	H2014	М	n5	U2		\$4.03	Practitioner Level 5, In-Clinic, without client present	H2014	HQ	HS	SU	90	\$3.30
Dractitioner Level 5, In-Clinic, with client present 15 minutes A therapeutic interaction shown to be successful with defined by the individual and specified in the Individual development, enhancement or maintenance of: 1. Illness and medication self-management knowle medications and side effects, and motivationalls. 2. Problem solving skills; 3. Healthy coping mechanisms; 4. Adaptive skills; 5. Interpersonal skills; 6. Daily living skills; 7. Resource management skills; 8. Knowledge regarding mental illness, substance of the skills; 9. Chill standard of the skills; 10. Chill standard of the skills; 11. Resource management skills; 12. Resource management skills; 13. Resource management skills; 14. Resource management skills;		Practitioner Level 4, In-Clinic, with client present	H2014	М	Ή	40	90	\$4.43	Practitioner Level 4, Out-of-Clinic, without client present	H2014	М	HS	104	U7	\$5.41
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A therapeutic interaction shown to be successful with defined by the individual and specified in the Individual development, enhancement or maintenance of: 1. Illness and medication self-management knowle medications and side effects, and motivationally. 2. Problem solving skills; 3. Healthy coping mechanisms; 4. Adaptive skills; 5. Interpersonal skills; 6. Daily living skills; 7. Resource management skills; 8. Knowledge regarding mental illness, substance of the still of the stills; 9. Chill of the stills; 10. Chill of the stills; 11. Illness substance of the still of the stills; 12. Chill of the still of the	Unit Value	15 minutes							Maximum Daily Units	20 units					
	Service Definition	A therapeutic interaction shown to b defined by the individual and specification by the individual and specification by the individual and specifications and medication self-ma medications and side effects, 3. Problem solving skills; Healthy coping mechanisms; Adaptive skills; Interpersonal skills; Daily living skills; Resource management skills; Knowledge regarding mental ills; Skills necessary to access and	e success ed in the li tenance o nagement and motive iness, sub	ful with and advisoring the stance astance astance	dentifie lized Re lized Re dge and dge and deve kill deve related of the designation of the light development.	d popula seiliency 1 skills (e ilopment disorder:	tions, of Plan. 9.9. sylvitin taki tin	diagnoses Services r mptom m ng medic	s and service needs. Services are may address goals/issues such as panagement, behavioral managemeation as prescribed);	directed t promoting ent, relaps	g recov	achieve ery, and ention s	d the rest kills, kno	specification storation st	c goals n, e of

Practitioners and supervisors of those providing this service are expected to maintain knowledge and skills regarding group practice such as selecting appropriate

The membership of a multiple family group (H0004 HQ) consists of multiple family units such as a group of two or more parent(s) from different families either

with (HR) or without (HS) participation of their child/children.

Requirements

Additional

Medicaid

Reporting

Billing &

Requirements

c,

Operations

Clinical

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	1. Individuals must have a mental illness/substance-related disorder diagnosis that is at least destabilizing (markedly interferes with the ability to carry out activities
Admission Criteria	of daily living or places others in danger) or distressing (causes mental anguish or suffering); and 2. The individual's level of functioning does not preclude the provision of services in an outpatient milieu; and 3. The individual's resiliency goal/s that are to be addressed by this service must be conducive to response by a group milieu.
Continuing Stay Criteria	1. Individual continues to meet admission criteria; and 2. Individual demonstrates documented progress relative to goals identified in the Individualized Recovery Plan, but recovery goals have not yet been achieved.
Discharge Criteria	An adequate continuing care plan has been established; and one or more of the following: 1. Goals of the Individualized Recovery Plan have been substantially met; or 2. Individual requests discharge and the individual is not in imminent danger of harm to self or others; or 3. Transfer to another service/level of care is warranted by change in individual's condition; or 4. Individual requires more intensive services.
Service Exclusions	See also Required Components, item 2. below.
Clinical Exclusions	 Severity of behavioral health issue precludes provision of services. Severity of behavioral health issue precludes provision of services in this level of care. Severity of cognitive impairment precludes provision of services in this level of care. There is a lack of social support systems such that a more intensive level of service is needed. This service is not intended to supplant other services such as IID/IDD Personal and Family Support or any day services where the individual may more appropriately receive these services with staff in various community settings. Individuals with the following conditions are excluded from admission unless there is clearly documented evidence of a psychiatric condition overlaying the diagnosis: Developmental Disability. Autism, Neurocognitive Disorder, Traumatic Brain Injury.
Required Components	 The functional goals addressed through this service must be specified and agreed upon by the individual. Group outpatient services should very rarely be offered in addition to day services such as Psychosocial Rehabilitation. Any exceptions must be clinically justified in the record and may be subject to scrutiny by the Administrative Services organization. Exceptions in offering group outpatient services external to day services include such sensitive and targeted clinical issue groups as incest survivor groups, perpetrator groups, and sexual abuse survivor groups. When an exception is clinically justified, services must not duplicate day services activities.
Staffing Requirements	Maximum face-to-face ratio cannot be more than 10 individuals to 1 direct service staff based on average group attendance.
Clinical	 Practitioners providing this service are expected to maintain knowledge and skills regarding group practice such as selecting appropriate participants for a particular group, working with the group to establish necessary group norms and goals, and understanding and managing group dynamics and processes. Out-of-clinic group skills training is allowable and clinically valuable for some individuals; therefore, this option should be explored to the benefit of the individual. In this event, staff must be able to assess and address the individual needs and progress of each individual consistently throughout the intervention/activity (e.g. in an example of teaching 2-3 individuals to access public transportation in the community, group training may be given to help each individual individual goals, etc.). In this event, staff must be able to assess public transportation in the community, group training may be given to help each individual goals, etc.).
Additional Medicaid Requirements	The daily maximum within a CSU for combined Group Training/Counseling is 4 units/day.

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Practitioner Level 2, Out-of-Clinic 90832 U2 U7 Practitioner Level 4, Out-of-Clinic 90832 U3 U7 Practitioner Level 4, Out-of-Clinic 90832 U4 U7 Practitioner Level 4, Via interactive audio and video and v	Individual Counseling			_	_		0	Obodo Dotoil	900	POM	_	_
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Practitioner Level 2 90836 GT U2 \$116.90	Practitioner Level 2, In-Clinic 90836 U2 U6	N2		91			\$116.90	Practitioner Level 2, Out-of-Clinic	90836	U2	10	\$140.28
	Practitioner Level 1 90836 GT U1	E		<u></u>			\$174.63	Practitioner Level 2	90836	GT	NS NS	\$116.90

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Individual Counseling	nseling	
Unit Value	1 encounter (Note: Time-in/Time-out is required in the documentation as it justifies Utilization Criteria TBD	
	A therapeutic intervention or counseling service shown to be successful with identified populations, diagnoses and service needs, provided by a qualified clinician. Techniques employed involve the principles, methods and procedures of counseling that assist the person in identifying and resolving personal, vocational, intrapersonal and interpersonal concerns. Individual counseling may include face-to-face in or out-of-clinic time with family members as long as the individual is present for part of the session and the focus is on the individual. Services are directed toward achievement of specific goals defined by the individual and specified in the Individualized Recovery Plan. These services address goals/issues such as promoting recovery, and the restoration, development, enhancement or	Case 1:16
Service Definition	Illness and medication self-management knowledge and skills (e.g., symptom management, behavioral management, relapse prevention skills, knowledge of medications and side effects, and motivational/skill development in taking medication as prescribed); Problem solving and cognitive skills; Healthy coping mechanisms; Adaptive behaviors and skills;	-cv-03088-ELF
	Knowledge regarding mental illness, substance related disorders and other relevant topics that assist in meeting the individual's or the support system's needs. Best/evidence-based practice modalities may include (as clinically appropriate): Motivational Interviewing/Enhancement, Cognitive Behavioral Therapy, Behavioral Modification, Behavioral Management, Rational Behavioral Therapy, Dialectical Behavioral Therapy, and others as appropriate to the individual and clinical issues to be addressed.	R Docu
Admission Criteria	Individual must have a mental illness/substance-related disorder diagnosis that is at least destabilizing (markedly interferes with the ability to carry out activities of daily living or places others in danger) or distressing (causes mental anguish or suffering); and The individual's level of functioning does not preclude the provision of services in an outpatient milieu.	ment 4
Continuing Stay Criteria	Individual continues to meet admission criteria; and. Individual demonstrates documented progress relative to goals identified in the Individualized Recovery Plan, but recovery goals have not yet been achieved. Adequate continuing care plan has been established: and one or more of the following:	48-73
Discharge Criteria	Goals of the Individualized Recovery Plan have been substantially met; or Individual requires continuing care plan have been substantially met; or Individual requests discharge and individual is not in imminent danger of harm to self or others; or Transfer to another service is warranted by change in individual's condition; or Individual requires a service approach that supports less or more intensive need.	Filed 11
Service Exclusions	ACT and Crisis Stabilization Unit services.	/29/2
Clinical Exclusions	Severity of behavioral health impairment precludes provision of services. Severity of cognitive impairment precludes provision of services in this level of care. There is a lack of social support systems such that a more intensive level of service is needed. Individuals with the following conditions are excluded from admission unless there is clearly documented evidence of a psychiatric condition overlaying the diagnosis: Developmental Disability, Autism, Neurocognitive Disorder and Traumatic Brain Injury.	23 Page 1
Required Components		.52 c
Clinical Operations	Practitioners and supervisors of those providing this service are expected to maintain knowledge and skills regarding current research trends in best/evidence-based counseling practices. 90833 and 90836 are utilized with E/M CPT Codes as an add-on for psychotherapy and may not be billed individually.	of 627

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Individual Counseling	ıseling
	 1. To promote access, providers may use Telemedicine as a tool to provide direct interventions to individuals for whom English is not their first language. Examples of this include: The use of one-to-one service intervention via Telemedicine, connecting the individual to a practitioner who speaks the individual's language versus use of interpreters; and/or The use of an interpreter via Telemedicine to support the practitioner in delivering the identified service.
Service Accessibility	Telemedicine may only be utilized when delivering this service to an individual for whom English is not their first language. The individual must consent to the use of this modality. This consent should be documented in the individual's record. The use of telemedicine should <u>not</u> be driven by the practitioner's/agency's convenience or preference.
	2. Additionally, telemedicine may be utilized for 90833 and 90836 when the service is combined with CPT E&M codes and delivered by a medical practitioner (Level U1 and U2).
Billing and Reporting Requirements	 When 90833 or 90836 are provided with an E/M code, these are submitted together to encounter/claims system. 90833 is used for any intervention which is 16-37 minutes in length. 90836 is used for any intervention which is 38-52 minutes in length. 90836 is used for any intervention which is greater than 53 minutes. 90837 is used for any intervention which is greater than 53 minutes. If a Medicaid claim for this service denies for a Procedure-to-Procedure edit, a modifier (59) can be added to the claim and resubmitted to the MMIS for payment with two exceptions: If the billable base code is either 90833 or 90836 and is denied for Procedure-to-Procedure edit, then a (25) modifier should be added to the claim resubmission. Appropriate add-on codes must be submitted on the same claim as the paired base code.
Documentation Requirements	When 90833 or 90836 are provided with an E/M code, they are recorded on the same intervention note but the distinct services must be separately identifiable. When 90833 or 90836 are provided with an E/M code, the psychotherapy intervention must include time in/time out in order to justify which code is being utilized. Time associated with activities used to meet criteria for the E/M service is not included in the time used for reporting the psychotherapy service.

Interactive Complexity	Somplexity													
Transaction Code	Code Detail	Code	Mod 1	Mod 2	Mod Mod Mod Rate 2 3 4	Mod 4	Rate	Code Detail	Code	Mod 1	Mod Mod 1 2	Mod 3	Mod Mod Rate 3	Rate
Interactive Complexity	Interactive complexity (List separately in addition to the code for primary procedure)	90785					\$0.00	Interactive complexity (List separately in addition to the code for primary procedure)	90785	16				\$0.00
Unit Value	1 Encounter													
Service Definition	Interactive Complexity is not a direct service but functions as a modifier to Psychiatric Treatment, Diagnostic Assessment, Individual Therapy, and Group Counseling. This modifier is used when: 1. Communication with the individual participant/s is complicated perhaps related to, e.g., high anxiety, high reactivity, repeated questions, or disagreement and therefore delivery of care is challenging. 2. Caregiver emotions/behaviors complicate the implementation of the IRP. 3. Evidence/disclosure of a sentinel event and mandated report to a third party (e.g., abuse or neglect with report to state agency) with initiation of discussion of the sentinel event and/or report with the individual and supporters.	rvice but fur participa and participa and participa mplicate the event ancethe individity.	inctions nt/s is o ne imple manda all and	ctions as a modifictions is complicated implementation or nandated report to and supporters.	stions as a modifier to Psyc s is complicated perhaps ri implementation of the IRP. andated report to a third pa and supporters.	Psychia aps rela IRP. ird parti	atric Trea Ited to, e. y (e.g., a	ctions as a modifier to Psychiatric Treatment, Diagnostic Assessment, Individual Therapy, and Group Counseling. Is is complicated perhaps related to, e.g., high anxiety, high reactivity, repeated questions, or disagreement and implementation of the IRP. In an and ated report to a third party (e.g., abuse or neglect with report to state agency) with initiation of discussion of the land supporters.	nt, Individu. y, repeatec state agen	al Thera d questi cy) with	apy, and ons, or o	l Group disagre on of dis	Counse ement a cussion	ling. nd of the

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 Use of play equipment, physical devices, interpreter or language as practitioner, or when the individual has no the intervention). 	hysical dev or when th	rices, ir e indivi	nterprete	er or tra	inslator evelope	to overcon ed or has lo	Use of play equipment, physical devices, interpreter or translator to overcome significant language barriers (when individual served is not fluent in same language as practitioner, or when the individual has not developed or has lost expressive/receptive communication skills necessary for interactive participation in the intervention).	hen individual ser ation skills neces:	ved is not fluent in same sary for interactive partici	pation in	
se elements are defined in tl	he specific	compe	anion se	rvice tc	which	this modiffe	These elements are defined in the specific companion service to which this modifier is anchored to in reporting/claims submission.	s submission.			Case 1:16-cv
When this code is submitted, there must be: a. Record of base service delivery code/s AND the b. Evidence within the multi-code service note whic during the intervention. The interactive complexity component relates only to the backhotheraby service.	d, there mu vice deliver multi-code ion. componen	ust be: ry code servic	sk AND se note v	the Inti which ir o the in	eractive ndicate: crease	Complexifies the specified work inte	When this code is submitted, there must be: a. Record of base service delivery code/s AND the Interactive Complexity code on the single note; and b. Evidence within the multi-code service note which indicates the specific category of complexity (from the list of items 1-4 in the definition above) utilized during the intervention. The interactive complexity component relates only to the increased work intensity of the psychotherapy service, but does not change the time for the psychotherapy service.	list of items 1-4 i but does not cha	n the definition above) utinge the time for the	lized	-03088-ELR
This service may only be re only when paired with 908. This Service Code paired w interpreter or translator is Lateractive Complexity is ut	eported/bill 33 or 9083 with the TG used during tilized as a	led in c 6: 992(3 modifi g the in modifie	conjunct 31, 9927 ier is on terventi	ion with 11, 992 ly used on. So, onerefor	one or 02, 992 when the of the order of the	the followi	This service may only be reported/billed in conjunction with one of the following codes: 90791, 90792, 90832, 90837, 90853, and with the following codes only when paired with 90833 or 90836: 99201, 99201, 99202, 99203, 99203, 99204, 99205, 99205, 99205. This Service Code paired with the TG modifier is only used when the complexity type from the Service Definition above is categorized under Item 4 AND an interpreter or translator is used during the intervention. So, if play equipment is the only complex intervention utilized, then TG is not utilized. Interactive Complexity is utilized as a modifier and therefore is not required in an order nor in an Individualized Recovery/Resiliency Plan.	0834, 90837, 908 15. n above is catego liized, then TG is Recovery/Resilier	53, and with the following rized under Item 4 AND and utilized.	g codes	Document 448-73
Administration Code Detail	Code	Mod 1	Mod 2	Mod 3	Mod 4	Rate	Code Detail	Code Mod	Mod 2 Mod Mod 3 4	Rate	Filed
Practitioner Level 2, In-Clinic	H2010	UZ	90 9			\$33.40	Practitioner Level 2, Out-of-Clinic	H2010 U2	1	\$42.51	11/
Practitioner Level 4, In-Clinic	H2010	U4	90			\$17.40	Practitioner Level 3, Out-of-Clinic Practitioner Level 4, Out-of-Clinic	+	0/ 0/	\$22.14	29/2
Practitioner Level 5, In-Clinic	H2010	U5	90			\$12.97	Practitioner Level 2. Out-of-Clinic	96372	70	\$42,51	23
Practitioner Level 3, In-Clinic	96372	U3	90			\$25.39	Practitioner Level 3, Out-of-Clinic		20	\$33.01	Pa
Practitioner Level 4, In-Clinic	96372	N4	90			\$17.40	Practitioner Level 4, Out-of-Clinic	96372 U4	U7	\$22.14	ıge .
ig services, methadone administration and/or service (provision of the drug by a licensed	tion and/or	service	(provisior	of the dr	ug by a li	censed	For individuals who need opioid maintenance, the Opioid Maintenance service should be requested	aintenance, the O	pioid Maintenance service	should	154 d
1 encounter							Utilization Criteria	1 encounter			of (
implined through this sand	vice modic	ation a	4ministr	ation in	ohinas	the act of i	As reimbursed through this service medication administration includes the art of introducing a duig (any chemical substance that when absorbed into the body of a	thetanna that wh	hod aft ofting the hod	o Jo	62

Exclusions

Documentation Requirements

Reporting and

Requirements

Billing

Continuing Stay

Discharge Criteria

Criteria

Clinical

Admission

Criteria

Medication A	Medication Administration													
Transaction Code	Code Detail	Code	Mod 1	Mod 2	Mod Mod Mod Rate	Mod 4	Rate	Code Detail	Code	Mod 1	Mod Mod 2	Mod Mod 3 4		Rate
	Practitioner Level 2, In-Clinic	H2010	U2	90			\$33.40	Practitioner Level 2, Out-of-Clinic	H2010	N2	107			\$42.51
Comprehensive	Practitioner Level 3, In-Clinic	H2010	EN	90			\$25.39	Practitioner Level 3, Out-of-Clinic	H2010 U3	N3	107			\$33.01
Medication	Practitioner Level 4, In-Clinic	H2010 U4	U4	90			\$17.40	Practitioner Level 4, Out-of-Clinic H2010 U4	H2010	D4	107			\$22.14
Selvices	Practitioner Level 5, In-Clinic	H2010 U5	U5	90			\$12.97							
Therapeutic,	Practitioner Level 2, In-Clinic	96372	U2	90		,	\$33.40	Practitioner Level 2, Out-of-Clinic	96372	N2	U2			\$42.51
prophylactic or	Practitioner Level 3, In-Clinic	96372	U3	90			\$25.39	Practitioner Level 3, Out-of-Clinic	96372	N3	107			\$33.01
diagnostic injection	Practitioner Level 4, In-Clinic	96372	V4	90			\$17.40	Practitioner Level 4, Out-of-Clinic 96372 U4 U7	96372	42	107			\$22.14
Alcohol, and/or dru	Alcohol, and/or drug services, methadone administration and/or service (provision of the drug by a licensed	on and/or s	ervice (r	novision	of the dru	g by a lic	ensed	For individuals who need opioid maintenance, the Opioid Maintenance service should	aintenance	, the Op	oioid Mainter	nance se	ervice sl	plnoq
program)			:					be requested						
Unit Value	1 encounter							Utilization Criteria	1 encounter	nter				
Conjos	As reimbursed through this servio	ce, medica	ition adı	ninistra	ition inc	sapni	the act of ir	As reimbursed through this service, medication administration includes the act of introducing a drug (any chemical substance that, when absorbed into the body of a	bstance th	ıat, whe	en absorbec	l into the	body (of a
Definition	living organism, alters normal bo	dily functio	n) into 1	he bod	y of and	other p	erson by ar	living organism, alters normal bodily function) into the body of another person by any number of routes including, but not limited to the following: oral, nasal, inhalant,	not limited	to the	following: o	ral, nas	al, inhal	lant,
	intramuscular injection, intravenc	ous, topical	, suppo	sitory o	r intrao	cular. I	Medication	intramuscular injection, intravenous, topical, suppository or intraocular. Medication administration requires a written service order for Medication Administration and a	ervice orde	er for M	edication A	dministr	ation aı	nd a

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	written order for the medication and the administration of the medication that complies with guidelines in Part II, Section 1, Subsection 6—Medication of the Provider Manual. The order for and administration of medication must be completed by members of the medical staff pursuant to the Medical Practice Act of 2009, Subsection 43-34-23 Delegation of Authority to Nurse and Physician Assistant and must be administered by licensed or credentialed* medical personnel under the supervision of a physician or registered nurse in accordance with O.C.G.A.	
	The service must include: 1. An assessment by the licensed/credentialed medical personnel administering the medication of the individual's physical/psychological/behavioral status in order to make recommendations regarding whether to continue medication and/or its means of administration, and whether to refer the individual to the physician for medication review. 2. Education to the individual, by appropriate licensed medical personnel, on the proper administration and monitoring of prescribed medication in accordance with	Case 1:16-c
	1. Individual presents symptoms that are likely to respond to pharmacological interventions; and 2. Individual has been prescribed medications as a part of the treatment array; and 3. Individual/family/responsible caregiver is unable to self-administer/administer prescribed medication because: a. Although the individual is willing to take the prescribed medication, it is in an injectable form and must be administered by licensed medical personnel; or b. Although individual is willing to take the prescribed medication, it is a Class A controlled substance which must be stored and dispensed by medical staff in	v-03088-ELR
	c. Administration by licensed/credentialed medical personnel is necessary because an assessment of the individual's physical, psychological and behavioral status is required in order to make a determination regarding whether to continue the medication and/or its means of administration and/or whether to refer the individual to the physician for a medication review. d. Due to the family/caregiver's lack of capacity there is no responsible party to manage/supervise self-administration of medication (refer individual /family for CSI and/or Family or Group Training in order to teach these skills).	Documen
Continuing Stay Criteria	Individual continues to meet admission criteria.	t 448
	 Individual no longer needs medication; or Individual is able to self-administer medication; and Adequate continuing care plan has been established. 	3-73
	 Does not include medication given as part of an Ambulatory Detoxification protocol. Medication administered as part of this protocol is billed as Ambulatory Detoxification. Must not be billed in the same day as Nursing Assessment. Must not be billed while enrolled in ACT except if this Medication Administration service is utilized only for the administration of methadone (for Medicaid recipients). May not be billed in conjunction with Intensive Day Treatment (Partial Hospitalization). 	Filed 11/29/23
	This service does <u>not</u> cover supervision of self-administration of medications. Self-administration of medications can be done by anyone physically and mentally capable of taking or administering medications to himself/herself. Youth and adults with mental health issues, or developmental disabilities are very often capable of self-administration of medications even if supervision by others is needed in order to adequately or safely manage self-administration of medication and other activities of daily living.	8 Page
	 There must be a written service order for Medication Administration and a written order for the medication and the administration of the medication that complies with guidelines in Part II, Section 1, Subsection 6 - Medication of the Provider Manual. The order for and administration of medication must be completed by members of the medical staff pursuant to the Medical Practice Act of 2009, Subsection 43-34-23 Delegation of Authority to Nurse and Physician Assistant. The order must be in the individual's chart. Telephone/verbal orders are acceptable provided they are signed by an appropriate member of the medical staff in accordance with DBHDD requirements. 	155 of 627

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		C
Staffing Requirements	2. This service does not include the supervision of self-administration of medication. Qualified Medication Aides working in a Community Living Arrangement (CLA) may administer medication only in a CLA.	ase 1
-	1. Medication administration may not be billed for the provision of single or multiple doses of medication that an individual has the ability to self-administer, either in a clinic or a community setting. In a group home/CCI setting, for example, medications may be managed by the house parents or residential care staff and kept locked up for safety reasons. Staff may hand out medication to the residents but this does not	L:16-cv-0
Operations	treatment services. 2. If individual/family requires training in skills needed in order to learn to manage his/her own medications and their safe self-administration and/or supervision of self-administration, this skills training service can be provided via the PSR-I, AD Support Services, or Family/Group Training services in accordance with the person's individualized recovery/resiliency plan.)3088-ELF
Billing & Reporting Requirements	If a Medicaid claim for this service denies for a Procedure-to-Procedure edit, a modifier (59) can be added to the claim and resubmitted to the MMIS for payment.	R Doo
Additional Medicaid Requirements	As in all other settings, the daily maximum within a CSU for Medication Administration is 1 unit/day.	cument
		448-
Nursing Ass	Nursing Assessment and Health Services	73

Nursing Ass	Nursing Assessment and Health Services	vices											
Transaction	Code Detail	Code	Mod	ро	poM poM	Mod	Rate	Code Detail	Code	Mod	Mod	poM poM	Rate
Code			1	7	3	4				_	7	3	
	Practitioner Level 2, In-Clinic	T1001	U2	90			\$38.97	Practitioner Level 2, Out-of-Clinic	T1001	NZ	70		\$46.76
	Practitioner Level 3, In-Clinic	T1001	U3	90			\$30.01	Practitioner Level 3, Out-of-Clinic	T1001	N3	70		\$36.68
	Practitioner Level 4, In-Clinic	T1001	U4	Ol6			\$20.30	Practitioner Level 4, Out-of-Clinic	T1001	N4	U7		\$24.36
Nursing	Practitioner Level 2, Via							Practitioner Level 4, Via					
Assessment/	interactive audio and video	T1001	GT	U2			\$38.97	interactive audio and video	T1001 GT	GT	4		\$20.30
Evaluation	telecommunication systems							telecommunication systems					
	Practitioner Level 3, Via												
	interactive audio and video	T1001 GT	GT	U3			\$30.01						
	telecommunication systems												
	Practitioner Level 2, In-Clinic	T1002	N2	9N			\$38.97	Practitioner Level 2, Out-of-Clinic	T1002	N2	U2		\$46.76
RN Services	Practitioner Level 3, In-Clinic	T1002	U3	90			\$30.01	Practitioner Level 3, Out-of-Clinic	T1002	N3	70		\$36.68
to 15 minutes	Practitioner Level 2, Via							Practitioner Level 3, Via					
	interactive audio and video	T1002	GT	U2			\$38.97	interactive audio and video	T1002	GT	<u> </u>		\$30.01
	telecommunication systems							telecommunication systems					
	Practitioner Level 4, In-Clinic	T1003	U4	N6			\$20.30	Practitioner Level 4, Out-of-Clinic	T1003	U4	U7		\$24.36

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Nuising Assessment and nearin services	200	/Ices										
Practitioner Level 4, Via interactive audio and video T1003 GT		GT		D4		\$20.30						
Practitioner Level 2, In-Clinic 96156 U2	+	U2	+	90	3,	\$38.97	Practitioner Level 2, Out-of-Clinic	96156	N2	10	\$62.35	
Practitioner Level 3, In-Clinic 96156 U3	1	U3	+	90		\$30.01	Practitioner Level 3, Out-of-Clinic	96156	U3	U2	\$48.91	
Practitioner Level 4, In-Clinic 96156 U4		D4		90		\$20.30	Practitioner Level 4, Out-of-Clinic	96156	U4	U7	\$32.48	
Practitioner Level 2, Via interactive audio and video 96156 GT telecommunication systems	GT			U2		\$38.97	Practitioner Level 4, Via interactive audio and video telecommunication systems	96156	GT	104	\$20.30	
Practitioner Level 3, Via interactive audio and video elecommunication systems	GT		_	U3		\$30.01)3088-EI
15 minutes for T codes, 1 encounter for code 96156	ır for code 96156	96156					Utilization Criteria	TBD				
This service requires face-to-face contact with the individual to monitor, evaluate, assess, and/or carry out a physician's orders regarding the physical and/or psychological problems of the individual. It includes: 1. Providing nursing assessments and interventions to observe, monitor and care for the physical, nutritional, behavioral health and related psychosocial issues, problems or crises manifested in the course of an individual's treatment:	contact with the in ividual. It includes: s and interventions in the course of an	with the in includes: erventions	ات تي چ و	dividual to	o monitor, (ve, monitor	evaluate, a	assess, and/or carry out a physician for the physical, nutritional, behavic	oral healt	regardi h and re	ing the phrelenger	ysical and/or chosocial issues,	
2. Assessing and monitoring individual's response to medication(s) to determine the need to continue medication and/or to determine the need to refer the individual for a medication review;	ividual's response to	esponse to	9 B	medica	tion(s) to d	etermine t	the need to continue medication and	d/or to de	termine	the need	to refer the indivi	dual
 Assessing and monitoring an individual's medical and other health issues that are either directly related to the mental health or substance related disorder, or to the treatment of the disorder (e.g. diabetes, cardiac and/or blood pressure issues, substance withdrawal symptoms, weight gain and fluid retention, seizures, etc.); Consulting with the individual and individual identified family and significant other(s) about medical, nutritional and other health issues related to the individual's mental health or substance related issues. 	individual's medical adiabetes, cardiac ar and individual-identiflated	's medical (, cardiac ar idual-identif	cal a	and othe Id/or blo ied fami	er health is: od pressur ily and sign	sues that are issues, and ifficant oth	other health issues that are either directly related to the mental health or substance related disorder, or tr blood pressure issues, substance withdrawal symptoms, weight gain and fluid retention, seizures, etc.); amily and significant other(s) about medical, nutritional and other health issues related to the individual's	ntal health reight gair other hea	or sub חי and flı alth issu	stance relaid retenti	ated disorder, or on, seizures, etc.) d to the individual	to the);
	any identified family al cardiac abnormalities and the individual-ide	fied family ab abnormalities	ily at alitie		tential mec lopment of	dication sic diabetes significant	potential medication side effects (especially those which may adversely affect health such as weight gain or velopment of diabetes or seizures, etc.); ed family and significant other(s) about the various aspects of informed consent (when prescribing occurs):	nay adver of inform	sely aff	ect health	such as weight g	ain or
	of medication;	cation;	5									1/2
 Venipuncture required to monitor and assess mental health, substance disorders or directly related conditions, and to monitor side effects of psychotropic medications, as ordered by as ordered by an appropriate member of the medical staff; and ordered passessment testing and referral for infections diseases 	itor and assess ment cordered by an appro and referral for infe	issess ment by an appro	nent ppro infe	al healt opriate r ≃tious d	h, substant nember of iseases	ce disorde the medic	ealth, substance disorders or directly related conditions, and te member of the medical staff; and soliseases	d to monif	tor side	effects of	psychotropic	
	oms that are likely to medications as a p	are likely to	a √	respon art of the	d to medical treatment	al/nursing array or h	interventions; or nas a confounding medical condition					
 Individual continues to demonstrate symptoms that are likely to respond to or are responding to medical interventions; or Individual exhibits acute disabling conditions of sufficient severity to bring about a significant impairment in day-to-day functioning; or Individual demonstrates progress relative to goals identified in the Individualized Recovery Plan, but recovery goals have not yet been achieved. 	strate symptoms that ling conditions of suffi	nptoms that itions of suffi re to goals ic	that suffi als ic	are like cient se dentified	ely to respo everity to b	and to or and indicated invidualized	ire responding to medical interventio t a significant impairment in day-to-c d Recovery Plan, but recovery goals	ons; or day functi s have no	oning; or	or en achiev	- ed.	ge 157
 An adequate continuing care plan has been established; and one or more of the following: Individual no longer demonstrates symptoms that are likely to respond to or are responding to medical/nursing interventions; or Goals of the Individualized Recovery Plan have been substantially met; or Individual requests discharge and individual is not in imminent danger of harm to self or others. 	olan has been establis ates symptoms that a covery Plan have bee and individual is not in	oeen establis otoms that a an have bee dual is not in	tablis nat a bee	shed; a re likely n subs	nd one or to respontantially me	more of tl d to or are et; or r of harm t	; and one or more of the following: ely to respond to or are responding to medical/nursing interbstantially met; or minent danger of harm to self or others.	rventions	; or			

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NULSING ASS	NUISING ASSESSINEIN AND REALIN SELVICES
Service Exclusions	ACT, Medication Administration, Opioid Maintenance.
Clinical Exclusions	Routine nursing activities that are included as a part of medication administration/methadone administration.
Required Components	 Nutritional assessments indicated by an individual's confounding health issues may be billed under this code (96150, 96151). No more than 8 units specific to nutritional assessments can be billed for an individual within a year. This specific assessment must be provided by a Registered Nurse or by a Licensed Dietician. This service does not include the supervision of self-administration of medication. Each nursing contact should document the checking of vital signs (Temperature, Pulse, Blood Pressure, Respiratory Rate, and weight, if medically indicated or if related to behavioral health symptom or behavioral health medication side effect) in accordance with general psychiatric nursing practice. Nursing assessments will assess health risks, health indicators, and health conditions given that behavioral health conditions, behavioral health medications, and physical health are intertwined. Personal/family history of Diabetes, Hypertension, and Cardiovascular Disease should be explored as well as tobacco use history, substance use history, blood pressure status, and Body Mass Index (BMI). Any sign of major health concerns should yield a medical referral to a primary health care physician/center.
Clinical Operations	1. Venipuncture services must include documentation that includes cannula size, insertion site, number of attempts, location, and individual tolerance of procedure. 2. All nursing procedures must include relevant individual centered education regarding the procedure.
	To promote access, providers may use Telemedicine as a tool to provide direct interventions to individuals for whom English is not their first language. Examples of this include: • the use of one-to-one service intervention via Telemedicine, connecting the individual to a practitioner who speaks the individual's language versus use
Service Accessibility	of interpreters; and/or the use of an interpreter via Telemedicine to support the practitioner in delivering the identified service.
	Telemedicine may only be utilized when delivering this service to an individual for whom English is not their first language. The individual must consent to the use of this modality. This consent should be documented in the individual's record. The use of telemedicine should not be driven by the practitioner's/agency's convenience or preference.
Billing & Reporting Requirements	 If a Medicaid claim for this service denies for a Procedure-to-Procedure edit, a modifier (59) can be added to the claim and resubmitted to the MMIS for payment. When Telemedicine technology is utilized for the provision of this service in accordance with the allowance in the Service Accessibility section of this definition, the code cited in the Code Detail above with the appropriate GT modifier shall be utilized in documentation and claims submission.
Additional Medicaid Requirements	The daily maximum within a CSU for Nursing Assessment and Health Services is 5 units/day.

Pharmacy & Lab	Lab
	Pharmacy and Lab Services include operating or purchasing services to order, package, and distribute prescription medications. It includes provision of assistance to
Service	individuals to access indigent medication programs, sample medication programs and payment for necessary medications when no other funding source is available.
Definition	This service provides for appropriate lab work, such as drug screens and medication levels to be performed. This service is to ensure that necessary medication and
	lab services are not withheld or delayed to individuals based on inability to pay.
Admission	Individual has been assessed by a prescribing professional to need a psychotropic, anti-cholinergic, substance use disorder-specific, or anti-convulsant (as related to
Criteria	behavioral health issue) medication and/or lab work required for persons entering services, and/or monitoring medication levels

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Continuing Stay Criteria		Individual continues to meet the admission criteria as determined by the prescribing professional	sion criter	ia as de	termin	ed by the pre	scribing p	rofessional.						
Discharge Criteria	- 2	 Individual no longer demonstrates symptoms that are likely to respond to or are responding to pharmacologic interventions; or Individual requests discharge and individual is not imminently dangerous or under court order for this intervention. 	symptoms i dividual i	that ar s not in	e likely minent	to respond to	or are restor or o	kely to respond to or are responding to pharmacologic intervent nently dangerous or under court order for this intervention.	tions; or					ı
Required Components	3.2.	 Service must be provided by a licensed pharmacy or through contract with a licensed pharmacy Agency must participate in any pharmaceutical rebate programs or pharmacy assistance progra Providers shall assist individuals who have an inability to pay for medications in accessing the Ic Administration to explore options for Medicaid eligibility. 	ised phari maceutic o have ai r Medicaid	macy o al reba n inabili	through the program to the parties.	h contract w ams or phar y for medica	ith a licens macy assis tions in ac	irough contract with a licensed pharmacy. promote individual access in obtaining medication. programs or pharmacy assistance programs that promote individual access in obtaining medication. to pay for medications in accessing the local Division of Family & Children Services or the Social Security	idual acce: & Childrer	ss in ob 1 Servic	otaining r	nedication. Social Sec	urity	Case 1
Additional Medicaid Requirements	N H	Not a Medicaid Rehabilitation Option "service." Medicaid r Health.	service."	Medica	d recipi	ents may ac	cess the g	ecipients may access the general Medicaid pharmacy program as defined by the Department of Community	as define	d by th∈	e Departi	ment of Cor	nmunity	:16-cv-
Reporting and Billing Requirements	上	The agency shall adhere to expectations set forth in its contract for reporting related information.	ns set fort	h in its	contrac	t for reportin	g related ir	ıformation.						-03088-
	ŀ													-ELR
Transaction Code De	c l re	eatment Code Detail	Code	Mod	Mod	Mod Mod	Rate	Code Detail	Code	Mod	Mod	Mod Mod	Rate	Dod
		0 -1 -1 -1 -1 -1 -1 -1 -1 -1 -1 -1 -1 -1	0000	_ =	2	3 4			0000	~ <u>-</u>		_	2	cun
	15 – 29		39202	5 2	9 1		97.00	-	39202	20 21	9 =		64.95	ner
	minutes	Practitioner Level 1, Out-or-Clinic Practitioner Level 1	99202	GT) [97.00	Practitioner Level 2, Out-or-Clinic Practitioner Level 2	99202	DZ CT	/n 07		64.95	nt 4
			99203	L1	90		155.20	Practitioner Level 2, In-Clinic	99203	N2	90		103.92	48-
3	30 – 44 minutes		99203	U1	U2		197.60	Practitioner Level 2, Out-of-Clinic	99203	U2	U2		124.72	-73
_		Practitioner Level 1	99203	GT	7		155.20	Practitioner Level 2	99203	GT	7 2 1		103.92	3
Patient 4	45 - 59		99204	5 1	20		271.70	Practitioner Level 2, Int-Ollino	99204	7 07	3 2		171.49	File
=	Spining	Щ	99204	GT	U		213.40	Practitioner Level 2	99204	GT	U2		142.89	d
	60 – 74		99205	U1	90		271.60	Practitioner Level 2, In-Clinic	99205	N2	90		181.86	
, E	minutes	Practitioner Level 1, Out-of-Clinic	99205	U1	10		345.80	Practitioner Level 2, Out-of-Clinic	99205	UZ CT	20		218.26	29/
		Practitioner Level 1, In-Clinic	99211	1	90		19.40	Practitioner Level 2, In-Clinic	99211	02	90		12.99	
	~ 5 minutes		99211	L1	U2		24.70	Practitioner Level 2, Out-of-Clinic	99211	N2	U2		15.59	
	,		99211	СT	U		19.40	Practitioner Level 2	99211	GT	U2		12.99	Pa
	10_10	Practitioner Level 1	99212	U1	90		58.20	Practitioner Level 2, In-Clinic	99212	U2	90		38.97	ıge
E/M	minutes	!	99212	1	U2		74.10	Practitioner Level 2, Out-of-Clinic	99212	N2	U2		46.77	: 1
hed	5	_	99212	GT	Ŋ		58.20	Practitioner Level 2	99212	GT	U2		38.97	59
Patient	20 - 00		99213	U1	90		97.00		99213	N2	90		64.95	of
	zu - za minutes		99213	10	17		123.50	-	99213	7 12	2		77.95	62
		Practitioner Level 1	99213	5 3	5 5		97.00	Practitioner Level Z	99213	5 5	70 :		04.90	.7

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Practitioner Level 2, In-Clinic

123.50 97.00 135.80

99213 99213 99214

90 IJ

5 GT

Practitioner Level 1, In-Clinic

30 - 39

UZ GT 7

99213 99213 99214

90.93

9 U2

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Psychiatric Treatment	eatment										
minutes	Practitioner Level 1, Out-of-Clinic Practitioner Level 1	99214 U1 99214 GT	1 T U1		172.90	Practitioner Level 2, Out-of-Clinic Practitioner Level 2	99214	UZ GT	U2 U2	109.13	
40 – 54 minutes		99215 U1 99215 U1	1 U6			Practitioner Level 2, In-Clinic Practitioner Level 2, Out-of-Clinic	99215 99215	N2 U2	Ue U2	129.90	Ca
		99215 GT		19		Practitioner Level 2	99215	GT	U2	129.90	se
Unit Value	 encounter (Note: Time-in/Time-out is required in the documentation as it justifies which code above is billed) 	ut is required	in the do	cumentation as it justi		Utilization Criteria	TBD				1:16
:	The provision of specialized medical and/or psychiatric services that inc a. Psychotherapeutic services with medical evaluation and mana morbidity between behavioral and physical health care issues) b. Assessment and monitoring of an individual's status in relation c. Assessment of the appropriateness of initiating or continuing s	cal and/or ps ces with med vioral and ph ring of an ind opriateness o	ychiatric ical eva ysical h ividual's f initiatii		, but ar rent incl reatmer	services that include, but are not limited to: uation and assessment of physiological phenomena (including co- uation and management including evaluation and assessment of physiological phenomena (including co- palth care issues); status in relation to treatment with medication; ig or continuing services.	of physio	ogical	phenomena (inclu	ding co-	6-cv-03088-E
Service Definition	Individuals must receive appropri Practice Act of 2009, Subsection identified by the individual and the	ate medical ir 43-34-23 Dele sir Individualiz	itervent egation ed Rec	ons as prescribed and of Authority to Nurse overy Plan (within the	d provic and Phy param	Individuals must receive appropriate medical interventions as prescribed and provided by appropriate members of the medical staff pursuant to the Medical Practice Act of 2009, Subsection 43-34-23 Delegation of Authority to Nurse and Physician Assistant that shall support the individualized goals of recovery as identified by the individual and their Individualized Recovery Plan (within the parameters of the person's informed consent).	medical the indivisent).	staff pu idualize	ursuant to the Med ed goals of recove	cal y as	ELR Do
	Note: For the purposes of this ma	nual, Psychia	tric Tre	atment is sometimes I	eferrec	Note: For the purposes of this manual, Psychiatric Treatment is sometimes referred to as "physician assessment" or "physician assessment and care."	ohysician	asses	sment and care."		ocum
Admission Criteria	Individual is determined to be in need of psychotherapy services and has comedical oversight; or Individual has been prescribed medications as a part of the treatment array.	in need of ps.	ychothe as a pa	apy services and has	; confou	apy services and has confounding medical issues which interact with behavioral health diagnosis, requiring rt of the treatment array.	ct with be	havior	al health diagnosis	, requiring	nent 448-
Continuing Stay Criteria	 Individual continues to meet the admission criteria; or Individual exhibits acute disabling conditions of sufficient severity to bring about a significant impairment Individual continues to present symptoms that are likely to respond to pharmacological interventions; or Individual continues to demonstrate symptoms that are likely to respond or are responding to medical in Individual continues to require management of pharmacological treatment in order to maintain symptom 	ling condition t symptoms th strate sympto	criteria; s of suft nat are I ms that t of pha	or icient severity to bring ikely to respond to ph are likely to respond macological treatmer	g about armaco or are r it in ord	Individual continues to meet the admission criteria; or Individual exhibits acute disabling conditions of sufficient severity to bring about a significant impairment in day-to-day functioning; or Individual continues to present symptoms that are likely to respond to pharmacological interventions; or Individual continues to demonstrate symptoms that are likely to respond or are responding to medical interventions; or Individual continues to require management of pharmacological treatment in order to maintain symptom remission.	day functi ; or	oning;	ō		73 Filed 1
Discharge Criteria	An adequate continuing care plan has been established; and one or more of the following: Individual has withdrawn or been discharged from service; or Individual no longer demonstrates symptoms that need pharmacological interventions.	plan has beer sen discharge ates sympton	n establ ed from ns that i	ished; and one or m c service; or need pharmacological	ore of t	he following: entions.					1/29/23
Service Exclusions	 Not offered in conjunction with ACT. Supervision time is not billable. Time spent on documentation is not billable. 	ACT.									Page
Clinical Exclusions	Services defined as a part of ACT.										160
Required Components	When providing psychiatric services to individuals who consultation with a qualified professional as approved to	ses to individu ssional as ap	als who		and/or)eaf Se	are deaf, deaf-blind, and/or hard of hearing, psychiatrists shall demonstrate training, supervision, or by DBHDD Office of Deaf Services.	demonst	ate tra	ining, supervision,	or	of 62
											27

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Case 1:16-cv-03088-	ELR	Doo	cument 448-73	Filed 1	11/29/23	Page 1	L61 of 627

Clinical Operations	As such, it is expected that practitioners will fully discuss treatment options with individuals and allow for individual choice when possible. Discussion of treatment options should include a full disclosure of the pros and cons of each option (e.g., full disclosure of medication/treatment regimen potential side effects, potential adverse reactions - including potential adverse reaction from not taking medication as prescribed and expected benefits). If such full disclosure is not possible or advisable according to the clinical judgment of the practitioner, this should be documented in the individual's chart (including the specific information that was not discussed and a compelling rationale for lack of discussion/disclosure). 2. Assistive tools, technologies, worksheets, etc. can be used by the served individual to facilitate communication about treatment, symptoms, improvements, etc. with the treating practitioner. If this work falls into the scope of Interactive Complexity, it is noted in accordance with that definition. 3. This service may be provided with Individual Counseling codes 90833 and 90836, but the two services must be separately identifiable. 4. For purposes of this definition, a "new patient" is an individual who has not received an E/M code service from that agency within the agency and has seen a non-physician for a BH Assessment, they are still considered a "new patient" until after the first E/M individual conditions are conditioned.
Service Accessibility	This service may be provided via telemedicine to any individual who consents to this modality. This consent should be documented in the individual's record. The use of telemedicine should not be driven by the practitioner's/agency's convenience or preference.
Additional Medicaid Requirements	 The daily maximum within a CSU for E/M is 1 unit/day. Even if a physician also has his/her own Medicaid number, the physician providing behavioral health treatment and care through this code should bill via the approved provider agency's Medicaid number through the Medicaid Category of Service (COS) 440.
Billing & Reporting Requirements	 Within this service group, a second unit with a U1 modifier may be used in the event that a Telemedicine Psychiatric Treatment unit is provided and it indicates a need for a face-to-face assessment (e.g. 99213GTU1 is billed and it is clinically indicated that a face-to-face by an on-site physician needs to immediately follow based upon clinical indicators during the first intervention, then 99213U1, can also be billed in the same day). Within this service group, there is an allowance for when a U2 practitioner conducts an intervention and, because of clinical indicators presenting during this intervention, a U1 practitioner needs to provide another unit due to the concern of the U2 supervisee (e.g., Physician's Assistant provides and bills 90805U2U6 and because of concerns, requests U1 intervention following his/her billing of U2 intervention). The use of this practice should be rare and will be subject to additional utilization review scrutiny. These E/M codes are based upon Time (even though recent CPT guidance allows the option of using either Medical Decision Making or Time). The Georgia Medicaid State Plan is priced on time increments and therefore time will remain the basis of justification for the selection of codes above for the near term. If a Medicaid claim for this service denies for a Procedure-to-Procedure edit, a modifier (25) can be added to the claim and resubmitted to the MMIS for payment. Despite recent CPT guidance, this service may not be billed for all time spent on an individual's case in a single day (i.e., pre- and post-appointment work that is not direct individual assessment and/or care). because this indirect time is already included in the service rate.

Psychiatric Treatment

<u>></u>	Rate	\$187.04
atholog	Code Mod Mod Mod Rate	
cho-pa	Mod 3	
nd psy	Mod 2	70
ality aı	Mod 1	U2
person	Code	96130 U2
diagnostic assessment of emotionality, intellectual abilities, personality and psycho-pathology)etail	\$155.87 Practitioner Level 2, Out-of-Clinic
emotion	Code Detail	Practiti
ment of		\$155.87
assess	ModModModRate234	
nostic	Mod 3	
$\dot{\sim}$	Mod 2	90
Psych	Mod 1	U2
sting –	Code	96130
Psychological Testing : Psychological Testing – Psychc	Code Detail	Practitioner Level 2, In-Clinic 96130 U2
Psychological [†]	Transaction Code	Psychological testing evaluation services by physician or other qualified health care professional, including integration of patient data, interpretation of

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	Ca	se 1:	16-cv-0	3088	3-ELR	D	ocum	ent 448	3-73	File	d 1	1/29/	/23 F	Pag	je 162	of 6	27
<u> </u>		\$187.04		\$93.52		\$40.59	\$48.71	\$40.59	\$93.52		\$40.59	\$48.71	\$40.59	\$93.52		\$40.59	\$48.71
o-patholog																	
d psych		107		10		90	10	V4	10 10		90	10	4 0	10		90	U7
ility an		U2		U2		U4	40	GT	U2		U4	D4	GT	U2		1 1	U4
persona		96131		96136		96136	96136	96136	96137		96137	96137	96137	96138		96138	96138
ostic assessment of emotionality, intellectual abilities, personality and psycho-pathology		Practitioner Level 2, Out-of-Clinic		Practitioner Level 2, Out-of-Clinic		Practitioner Level 4, In-Clinic	Practitioner Level 4, Out-of-Clinic	Practitioner Level 4, Via interactive audio and video telecommunication systems	Practitioner Level 2, Out-of-Clinic		Practitioner Level 4, In-Clinic	Practitioner Level 4, Out-of-Clinic	Practitioner Level 4, Via interactive audio and video telecommunication systems	Practitioner Level 2, Out-of-Clinic		Practitioner Level 4, In-Clinic	Practitioner Level 4, Out-of-Clinic
sment of e	155.87	\$155.87	155.87	\$77.94	\$77.94	\$60.02	\$73.36	\$60.02	\$77.94	\$77.94	\$60.02	\$73.36	\$60.02	\$77.94	\$77.94	\$60.02	\$73.36
o-diagr	U2	90	U2	90	U2	90	U7	U3	90	U2	90	U7	EN	90	U2	90	70
Sycho	GT	N2	GT	U2	GT	EN	U3	GT	U2	GT	U3	U3	19	U2	GT	U3	U3
sting – F	96130	96131	96131	96136	96136	96136	96136	96136	96137	96137	96137	96137	96137	96138	96138	96138	96138
Testing : Psychological Testing – Psycho-diagn	Practitioner Level 2, Via interactive audio and video telecommunication systems	Practitioner Level 2, In-Clinic	Practitioner Level 2, Via interactive audio and video telecommunication systems	Practitioner Level 2, In-Clinic	Practitioner Level 2, Via interactive audio and video telecommunication systems	Practitioner Level 3, In-Clinic	Practitioner Level 3, Out-of- Clinic	Practitioner Level 3, Via interactive audio and video telecommunication systems	Practitioner Level 2, In-Clinic	Practitioner Level 2, Via interactive audio and video telecommunication systems	Practitioner Level 3, In-Clinic	Practitioner Level 3, Out-of- Clinic	Practitioner Level 3, Via interactive audio and video telecommunication systems	Practitioner Level 2, In-Clinic	Practitioner Level 2, Via interactive audio and video telecommunication systems	Practitioner Level 3, In-Clinic	Practitioner Level 3, Out-of- Clinic
Psychological T	standardized test results and clinical data, dinical decision making, treatment planning and report and interactive feedback to the patient, family member(s) or caregiver(s), when performed; first hour	Each additional hour / liet	separately in addition to code for primary procedure)		Psychological or neuropsychological test	physician or other qualified health care professional two	or more tests, any method, first				Each additional 30 minutes (List separately in addition to	code for primary procedure)			Psychological or neuropsychological test	administration and scoring by technician	

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Psychological	Testing : Psychological Te	sting – F	Sycho	-diagno	stic assess	ment of e	Psychological Testing : Psychological Testing – Psycho-diagnostic assessment of emotionality, intellectual abilities, personality and psycho-pathology	persona	ality and	d psycho-patholog	3y	
	Practitioner Level 3, Via	06138	ΤÜ	<u>2</u>		¢60.02	Practitioner Level 4, Via interactive	06138	T	<u> </u>	\$40.50	
	telecommunication systems	30130	5	3		\$00.00¢	systems	00106	5	t	۵. د. د. د.	
	Practitioner Level 2, In-Clinic	96139	U2	90		\$77.94	Practitioner Level 2, Out-of-Clinic	96139	U2	U7	\$93.52	Cá
	Practitioner Level 2, Via interactive audio and video telecommunication systems	96139	GT	U2		\$77.94						ase 1:1
Each additional 30 minutes	Practitioner Level 3, In-Clinic	96139	U3	9N		\$60.02	Practitioner Level 4, In-Clinic	96139	PO	9N	\$40.59	.6-c
(List Separately) in addition to code for primary procedure)	Practitioner Level 3, Out-of- Clinic	96139	U3	107		\$73.36	Practitioner Level 4, Out-of-Clinic	96139	U4	70	\$48.71	v-0308
	Practitioner Level 3, Via	96139	GT	U3		\$60.02	Practitioner Level 4, Via interactive	9613	GT	104	\$40.59	8-E
	interactive audio and video telecommunication systems						audio and video telecommunication systems					ELR
Unit Value	1 hour or 30 minutes						Utilization Criteria	TBD				
	Psychological testing consists of intellectual abilities using an objective interpretation of results is based.	s of a face objective a sed.	e-to-face and star	e assessi ndardizec	ment of emot I tool that has	tional funct s uniform p	Psychological testing consists of a face-to-face assessment of emotional functioning, personality, cognitive functioning (e.g., thinking, attention, memory) or intellectual abilities using an objective and standardized tool that has uniform procedures for administration and scoring and utilizes normative data upon which interpretation of results is based.	ning (e.g., oring and	thinking utilizes ı	,, attention, memory normative data upor) or ı which	Docume
Service Definition	Psychological tests are only a test ensures that the testing of privacy and confidentiality.	administer environme	red and	interpret not inter	ed by those v fere with the	who are pr performar	Psychological tests are only administered and interpreted by those who are properly trained in their selection and application. The practitioner administering the test on a continent affords adequate protections of privacy and confidentiality.	pplicatior t the envii	r. The pi	actitioner administe affords adequate p	ring the rotections	ent 448-73
	This service covers both the (with the proper education ar	face-to-faon nd training	ce admi) interpr	inistration eting the	of the test ir test rest ir	nstrument(This service covers both the face-to-face administration of the test instrument(s) by a qualified examiner as well as the time spent by a psychologist or physician (with the proper education and training) interpreting the test results and preparing a written report in accordance with CPT procedural guidance.	the time th CPT pr	spent by ocedura	r a psychologist or p al guidance.	hysician	3 F
Admission Criteria	A known or suspected mental illness or substance-related disorder; and Initial screening/intake information indicates a need for additional undeta Individual meets DBHDD eligibility.	iental illne iformation eligibility	ss or su indicate	ubstance- es a neec	related disor I for addition	der; and al undeterr	A known or suspected mental illness or substance-related disorder; and Initial screening/intake information indicates a need for additional undetermined supports and recovery/resiliency planning; and Individual meets DBHDD eligibility.	cy plannii	յց; and			iled 11
Continuing Stay Criteria	The individual's situation/functioning has changed in such a way that previous assessments are outdated.	ctioning he	as chan	ged in su	ch a way tha	ıt previous	assessments are outdated.					/29/2
Discharge Criteria	Each intervention is intended	to be a di	iscrete t	ime-limit	ed service th	at modifies	Each intervention is intended to be a discrete time-limited service that modifies treatment/support goals or is indicated due to change in illness/disorder.	ted due to	change	e in illness/disorder.		3
Staffing Requirements	The term "psychologist" is de	fined in th	ie Appro	ved Beh	avioral Healt.	h Practitior	The term "psychologist" is defined in the Approved Behavioral Health Practitioners table in Section II of this manual (Reference § 43-39-1 and § 43-39-7)	Referer	ce § 43	-39-1 and § 43-39-7).	Pag
Required Components	 There may be no more than 10 combined hours of the codes above provided to one indivious. When providing psychological testing to individuals who are deaf, deaf-blind, or hard of he consultation with a qualified professional as approved by DBHDD Office of Deaf Services. 	han 10 col ogical test ied profes	mbined ing to ir sional a	hours of idividuals is approv	the codes ak who are des ed by DBHD	oove provic af, deaf-blir D Office o	There may be no more than 10 combined hours of the codes above provided to one individual within an authorization. When providing psychological testing to individuals who are deaf, deaf-blind, or hard of hearing, practitioner shall demonstrate training, supervision, and/or consultation with a qualified professional as approved by DBHDD Office of Deaf Services.	ization. ıall demor	ıstrate tı	raining, supervision,	and/or	e 163 o
Clinical Operations	The individual (and caregiver	/responsik	ble fami	ly membe	ərs etc. as ap	opropriate)	The individual (and caregiver/responsible family members etc. as appropriate) must actively participate in the assessment processes.	ssment pı	ocesse:	ø.		f 62
Documentation Requirements	In addition to the authorization produced through this placed in the individual's chart.	in produce rt.	ed throu		ervice, docun	nentation c	service, documentation of clinical assessment findings from this service should also be completed and	his servic	olnous e	l also be completed	and	7
					r							

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Case 1.10-CV-03000-LLR	Ducument 440-73	LIIEU 11/29/23	raye 104 01 021

Psychological ⁻	Psychological Testing: Psychological Testing – Psycho-diagnostic assessment of emotionality, intellectual abilities, personality and psycho-pathology
	To promote access, providers may use Telemedicine as a tool to provide direct interventions to individuals for whom English is not their first language. Examples of this include:
	 the use of one-to-one service intervention via Telemedicine, connecting the individual to a practitioner who speaks the individual's language versus use of interpreters; and/or
Service Accessibility	 the use of an interpreter via Telemedicine to support the practitioner in delivering the identified service.
	Telemedicine may only be utilized when delivering this service to an individual for whom English is not their first language. The individual must consent to the use of this modality. This consent should be documented in the individual's record. The use of telemedicine should <u>not</u> be driven by the practitioner's/agency's convenience or preference.
Billing & Reporting Requirements	 Each unique code cannot be billed more than 5 units on a single day. Add-on codes shall be provided on the same day as the associated base code). Scoring may occur and be billed on a different day than the evaluation and testing procedures (and related codes). If a Medicaid claim for this service denies for a Procedure-to-Procedure edit, a modifier (59) can be added to the claim and resubmitted to the MMIS for payment. When Telemedicine technology is utilized for the provision of this service in accordance with the allowance in the Service Accessibility section of this definition, the code cited in the Code Detail above with the appropriate GT modifier shall be utilized in documentation and claims submission.

Psychosocia	Psychosocial Rehabilitation - Individual	dual												
Transaction	Code Detail	Code	Mod	poM po	Mod	Mod	Rate	Code Detail	Code	Mod	Mod	Mod Mod Mod	Mo	Rate
Code			_	7	က	4				_	7	က	d 4	
	Practitioner Level 4, In-Clinic	H2017	뽀	D14	90		\$20.30	Practitioner Level 4, Out-of-Clinic	H2017	뽀	V4	U2		\$24.36
-	Practitioner Level 5, In-Clinic	H2017	뽀	n2	90		\$15.13	Practitioner Level 5, Out-of-Clinic	H2017	뽀	C2	U2		\$18.15
Psychosocial	Practitioner Level 4, Via							Practitioner Level 5, Via						
אפוומטווומ	interactive audio and video	H2017	GT	<u></u> ሦ	V	90	\$20.30	interactive audio and video	H2017	GT	뽀	U5	90	\$15.13
	telecommunication systems							telecommunication systems						
Unit Value	15 minutes							Utilization Criteria	TBD					
	Psychosocial Rehabilitation-Ind	ividual (PS	R-I) 8	ervices (consist	of rehat	oilitative skills	Psychosocial Rehabilitation-Individual (PSR-I) services consist of rehabilitative skills building, the personal development of environmental and recovery supports	t of enviror	nmenta	ıl and re	scovery	ıoddns	ts
	considered essential in improvir	ng a persor	n's ful	nctioning	, learnir	skills	to promote t	considered essential in improving a person's functioning, learning skills to promote the person's self-access to necessary services and in creating environments that	ry services	and in	creatir	ig envird	nment	s that
	promote recovery and support t	he emotior	na lan	d functio	nal imp	roveme	nt of the indi	promote recovery and support the emotional and functional improvement of the individual. The service activities of Psychosocial Rehabilitation-Individual include:	shosocial R	ehabili	itation-l	ndividua	Il inclu	de:
	1. Providing skills support in the person's self-articulation of personal goals and objectives;	n the perso	n's s	elf-articul	ation of	person	al goals and	objectives;						
	2. Assisting the person in the development of skills to self-manage or prevent crisis situations;	develop	ment	of skills t	o self-n	nanage	or prevent c	risis situations;						
0	3. Individualized interventio	ns in living	ı, lear	ing, wor	rking, of	her soc	ial environm	3. Individualized interventions in living, learning, working, other social environments, which shall have as objectives:						
Definition	a. Identification, with the person, of	, with the p	ersol	n, of strei	ngths w	hich ma	y aid him/he	strengths which may aid him/her in achieving recovery, as well as barriers that impede the development of skills	arriers tha	t impec	de the c	levelopr	nent of	skills
	necessary fo	or functionir	in gr	vork, wit	h peers	, and wi	necessary for functioning in work, with peers, and with family/friends;	nds;						
	b. Supporting skills development to	kills develo	pme		d natura	oddns Is	rts (including	build natural supports (including support/assistance with defining what wellness means to the person in order to	hat wellne	ss mea	ns to th	ne perso	n in or	der to
	assist them with recovery-based	with recove	ery-ba		setting	and att	goal setting and attainment);							
	c. Assistance in	n the devel	opme	nt of inte	rpersor	nal, com	munity copir	Assistance in the development of interpersonal, community coping and functional skills (which may include adaptation to home, adaptation to work,	nclude ada	ptation	to hon	ne, adap	tation	to work,
	adaptation to	b healthy so	ocial (environm	ents, le	arning/p	oracticing ski	adaptation to healthy social environments, learning/practicing skills such as personal financial management, medication self-monitoring, symptom	gement, m	edicatic	on self-	monitori	ng, syr	nptom
	self-monitoring, etc.);	ng, etc.);												

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Psychosocia	Psychosocial Renabilitation - Individual
	d. Assistance in the acquisition of skills for the person to self-recognize emotional triggers and to self-manage behaviors related to the behavioral
	e. Assistance with personal development, work performance, and functioning in social and family environments through teaching skills/strategies to
	-
	g. Assist the person in his/her skills in gaining access to necessary rehabilitative, medical, social and other services and supports;
	ii. Assisialice to tile person and otref supporting hatara lesources with miress understaining and sen-management (including medication sen-monitoring); and
	individual and named natural supporters, of risk indicators related to substance related disorder relapse, and the development
	of skills and strategies to prevent relapse.
	This service is provided in order to promote stability and build towards functioning in the person's daily environment. Stability is measured by a decreased number of
	hospitalizations, by decreased frequency and duration of crisis episodes and by increased and/or stable participation in community/work activities. Supports based on
	the person's needs are used to promote recovery while understanding the effects of the mental lillness and/or substance use disorder, and to promote functioning.
	1. Individuals with one of the following: Mental Health (MH) Diagnosis, Co-Occurring Substance Use Disorder and MH Diagnosis, or Co-Occurring MH Diagnosis and
Admission	Developmental Disabilities (リレ) and one or more of the following:
Criteria	 Individual may need assistance with developing, maintaining, or ennancing social supports or other community coping skills; or Individual may need assistance with delivering plant including coordination to accept to accept the plant included and includ
:	5. Individual flay fleed assistance with daily fiving skills finduling coordination to gain access to fleessary ferabilitative and fledical services.
Continuing Stay	1. Individual continues to meet admission criteria; and
Criteria	2. Individual demonstrates documented progress or maintenance of community skills relative to goals identified in the Individualized Recovery Plan.
	1. An adequate continuing care plan has been established; and one or more of the following:
Discharge	2. Goals of the Individualized Recovery Plan have been substantially met; or
Criteria	3. Individual requests discharge and the individual is not in imminent danger of harm to self or others; or
	4. Transfer to another service/level of care is warranted by change in individual's condition; or
	5. Individual requires more intensive services.
امونعنات	1. There is a significant lack of community coping skills such that a more intensive service is needed.
Fychisions	2. Individuals with the following conditions are excluded from admission unless there is clearly documented evidence of a co-occurring Behavioral Health condition:
Lycidalolla	Developmental Disability, Autism, Neurocognitive Disorder, Traumatic Brain Injury.
	1. Psychosocial Rehabilitation-Individual services must include a variety of interventions in order to assist the individual in developing:
	 b. Strategies and supportive interventions for avoiding out-of-community treatment for adults and building stronger knowledge of the adult's strengths and limitations
	c. Relapse prevention strategies and plans.
	2. Psychosocial Rehabilitation-Individual services focus on building and maintaining a therapeutic relationship with the individual and facilitating treatment and
Required	recovery goals.
Components	3. Contact must be made with the individual receiving PSR-I services a minimum of twice each month.
	5. There may be instances where a person has an order and authorization to receive PSR-Group in addition to PSR-I. When the person is in attendance at the PSR-
	Group program and a staff provides support to the served individual on a one-to-one basis, the PSR Specialty provider may bill this PSR-I code. In this specific
	circumstance, the PSR group program shall not count for that time within in its hourly claims submission. There must be a PSR-I note which is individualized and
	Indicates the one-to-one nature of the intervention.

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Psychosocia	Psychosocial Rehabilitation - Individual	idual											
	6. When the primary focus of PSR-I is for medication maintenance, the following allowances apply:	PSR-I is fo	or medic	ation ma	intenance	, the follow	/ing allo	wances apply:					
	a. These individuals are	onot count	ed in the	offsite	service rec	quirement o	or the inc	a. These individuals are not counted in the offsite service requirement or the individual-to-staff ratio; and		(-		
	b. These individuals are not counted in the monthly	e not count billable ser	ed in the	e monthl		ace contac	t require	face-to-face contact requirement; however, face-to-face contact is required every 3 months and monthly	ot is required e	very 3 mo	onths and m	onthly	(
Staffing	PSR-I practitioners may have t	he recomr	nended	individua	Il-to-staff r	atio of 30 ii	ndividua	PSR-I practitioners may have the recommended individual-to-staff ratio of 30 individuals per staff member and must maintain a maximum ratio of 50 individuals per	lain a maximu	m ratio of	50 individu	als per	Ca
Requirements	staff member. Individuals who receive only medication maintenance are not counted in the staff ratio calculation.	eceive onl	y medica	ation ma	intenance	are not cou	unted in	the staff ratio calculation.					se
	1. The organization must hav.	e a Psycho	social F	Rehabilita	ation-Indiv	idual Orgal	nizationa	1. The organization must have a Psychosocial Rehabilitation-Individual Organizational Plan that addresses the following:					1::
	a. Description of the par	rticular reh	ıabilitatic	in, recov	ery and na	atural supp	ort deve	Description of the particular rehabilitation, recovery and natural support development models utilized, types of intervention practiced, and typical daily	tervention pra	cticed, ar	nd typical da	ily	16-
		:	:			:	:	:					·cv
	b. Description of the sta	affing patte	rn and h	iow staff	are deplo	yed to assu	ıre that t	Description of the staffing pattern and how staff are deployed to assure that the required staff-to-individual ratios are maintained, including how unplanned	s are maintaine	ed, includ	ing how unp	lanned	·-O:
		ses, or en	iergenci	es are a	commode	ated, case r	mix, acc	ess, etc.;					30
Clinical	c. Description of the hor	urs of oper	rations a	s related	to acces	s and avail	ability to	Description of the hours of operations as related to access and availability to the individuals served;					88
Operations		e plan for	services	is modi	ied or adjı	usted to me	eet the n	Description of how the plan for services is modified or adjusted to meet the needs specified in every Individualized Recovery Plan; and	ed Recovery F	Plan; and			3-E
	 If the service is offered through an agency which 	ed through	an ager	lcy whicl		PSR-Grou	nb, then	provides PSR-Group, then there is a description of how the agency has protocols and accountability	ency has proto	ocols and	accountabil	ıţ	LF
		that there	is no du	uplication	of billing	when the p	serson is	of billing when the person is being supported through the group model	model.				7
	Utilization (frequency and ii	ntensity) o	f PSR-I	a pinous	e directly ı	related to tl	he ANS/	Utilization (frequency and intensity) of PSR-I should be directly related to the ANSA and to other functional elements in the assessment. In addition, when	n the assessm	nent. In ac	dition, wher	_	
	clinical/functional needs an	e great, th	ere shou	oo eq pli	mplement	ary therape	eutic ser	clinical/functional needs are great, there should be complementary therapeutic services by licensed/credential professionals paired with the provision of PSR-I	ionals paired v	with the p	rovision of F	SR-I	Do
	(individual, group, family, etc.).	tc.).											CL
	 There must be documented evidence that service hour 	d evidence	that ser	rvice hou		ation incluc	de eveni	s of operation include evening, weekend, and holiday hours.					ım
	-	rack," indi	viduals	who requ		han 4 cont	acts per	ire more than 4 contacts per quarter for two consecutive quarters (as based upon need) are expected to be	's (as based u	pon need	l) are expect	ed to be	en
	re-evaluated with ANSA for enhanced access to PSR-I	r enhance	d access	to PSR		signation of	f PSR-I	. The designation of PSR-I "medication maintenance track" should be lifted and exceptions stated above are	uld be lifted a	nd except	tions stated	above are	ıt 4
													148
	3. To promote access, providers may use Telemedicine a	ers may us	se Telen	nedicine	as a tool t	o provide c	lirect into	is a tool to provide direct interventions to individuals for whom English is not their first language. Examples	english is not t	heir first l	anguage. E	kamples	3-7
Service	or this include:												3
Accessibility	• the use of one-to	o-one serv	ice inter	vention \	ria Teleme	dicine, cor	necting	the use of one-to-one service intervention via Telemedicine, connecting the individual to a practitioner who speaks the individual's language versus use	speaks the inc	dividual's	language ve	ersus use	F
	ol Illeipieleis, alid/ol	IO/OII				;							-il
	 the use of an interpreter via Telemedicine to 	erpreter vi	a Telem	edicine t	_	the practiti	oner in c	support the practitioner in delivering the identified service.					ed
	Telemedicine may only be utilized when delivering this	utilized wh	nen deliv	erina thi		o an individ	dual for	service to an individual for whom English is not their first language. The individual must consent to the use	age. The indiv	idual mus	st consent to	the use	11
	of this modality. This conse	ent should	be docu	mented	in the indiv	idual's rec	ord. The	of this modality. This consent should be documented in the individual's record. The use of telemedicine should not be driven by the practitioner's/agency's	driven by the	practition	er's/agency'	S	/29
	convenience or preference.												/2:
Billing &	1. Unsuccessful attempts to make contact with the individual are not billable.	nake conta	act with t	he indivi	dual are n	ot billable.							3
Reporting		ology is uti	lized for	the prov	ision of thi	s service ir	n accord	When Telemedicine technology is utilized for the provision of this service in accordance with the allowance in the Service Accessibility section of this definition, the	vice Accessibil	ity section	n of this defi	nition, the	Р
Kequirements	code cited in the Code Det	all above v	with the	appropri	ate GI mo	differ shall	be utiliz	code cited in the Code Detail above with the appropriate GT modifier shall be utilized in documentation and claims submission.	omission.				ag
													je 1
Service Plan	Service Plan Development												66
Transaction	Code Detail	Code	Mod 1	Mod	Mod I	Mod Rate		Code Detail C	Code Mod	Mod N	Mod Mod	Rate	of 6
Service Plan	Practitioner Level 2 In-Clinic	H0032	112	1 16			\$38 97 P	Practitioner Level 2 Out-of-Clinic	H0032 112	_	_	\$46.76	27
ספו אוכט - ומוו	ו ומטוווטווסו בסיטי ב, יוו טוווייט	1000	7	?		Ş́ →				5)))	,

	Rate	\$46.76
	Mod Mod Mod Rate	
	Mod 3	
	Mod 2	20
	Mod 1	N2
	Code	H0032
	Code Detail	Practitioner Level 2, Out-of-Clinic
		\$38.97
	Mod Rate	
	Mod 3	
	Mod 2	90
	Mod 1	U2
	Code Mod	H0032
Service Plan Development	Code Detail	Practitioner Level 2, In-Clinic
Service Plan	Transaction Code	Service Plan Development

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Service Plan	Service Plan Development										
	Practitioner Level 3, In-Clinic	H0032	U3	9N	\$30.01	Practitioner Level 3, Out-of-Clinic		H0032	 En	12 \$36	\$36.68
	Practitioner Level 4, In-Clinic	H0032	U4	90	\$20.30	Practitioner Level 4, Out-of-Clinic	Out-of-Clinic	H0032	40	U7 \$2	\$24.36
	Practitioner Level 5, In-Clinic	H0032	U5	ne e	\$15.13	Practitioner Level 5, Out-of-Clinic	Out-of-Clinic	H0032	US I	U7 \$18	\$18.15
	Practitioner Level 2, Via interactive audio and video	H0032	GT	U2	38.97	Practitioner Level 4, Via interactive audio and video	Via 1 video	H0032	GT	U4 20.	08:02
	telecommunication systems					telecommunication systems	systems				e
	Practitioner Level 3, Via interactive audio and video	H0032	GT	U3	30.01	Practitioner Level 5, Via interactive audio and video	Via 1 video	H0032	ET E	U5 15.	1:16
	telecommunication systems					telecommunication systems	systems				S-C
Unit Value*	15 minutes					Utilization Criteria		TBD			v-C
	Individuals access this service when it has been determined through an assessment that the individual has mental health or substance use disorder concerns. The Individualized Recovery Plan (IRP) results from the Diagnostic and Behavioral Health Assessments and is required within the first 30 days of service, with ongoing plans completed as demanded by individual need and/or by service policy.	when it has RP) results by individu	s been di from the al need	etermined through an as: e Diagnostic and Behavid and/or by service policy.	sessment oral Healt	that the individual he Assessments and I	as mental healtl is required withi	n or subst n the first	ance us 30 days	through an assessment that the individual has mental health or substance use disorder concerns. The tic and Behavioral Health Assessments and is required within the first 30 days of service, with ongoing service policy.	03088-I
	Information from a comprehensive assessment should ultimately be used to develop with the individual an IRP that supports recovery and is based on goals identified	ive assess	ment sh	ould ultimately be used to	o develop	with the individual a	n IRP that supp	orts recov	ery ano	l is based on goals ident	
	by the individual. Friends, family and other natural supports planned. Also, as indicated, medical, nursing, peer support, disciplinary assessments for the development of the IRP.	y and othe dical, nursi developm	r natural ing, peer ient of th	supports may be include support, community sur le IRP.	ed at the c oport, nutr	liscretion and directic itional staff, etc. sho	on of the individ uld provide infor	ual for wh mation fro	om serv om reco	may be included at the discretion and direction of the individual for whom services/supports are being community support, nutritional staff, etc. should provide information from records, and various multi-	
Service	The comerstone component of the IRP involves a discussion with the individual regarding what recovery means to him/her personally (e.g., getting/keeping a job, having more friends/improved relationships, improvement of behavioral health symptoms, etc.), and the development of goals (i.e. outcomes) and objectives that are defined by and meaningful to the individual based upon his/her articulation of their recovery hopes. Concurrent with the development of the IRP, the individual should be offered the opportunity to develop an Advanced Directive for behavioral healthcare with the individual guiding the process through the free expression of their wishes and through his/her assessment of the components developed for the Advanced Directive as being realistic for him/her.	the IRP inveluentionship e individue velop an A	volves a s, impro al based dvancec	discussion with the indiv vement of behavioral hea upon his/her articulation I Directive for behavioral	idual rege alth sympi of their re healthcar	toms, etc.), and the cacery toms, etc.), and the cacery hopes. Conca with the individual	means to him/r sevelopment of a urrent with the c guiding the proc	ler person goals (i.e. levelopme cess throum	ially (e.g outcon ent of th igh the f	behavioral health symptoms, etc.), and the development of goals (i.e. outcomes) and objectives that are behavioral health symptoms, etc.), and the development of goals (i.e. outcomes) and objectives that are ner articulation of their recovery hopes. Concurrent with the development of the IRP, the individual should for behavioral healthcare with the individual guiding the process through the free expression of their	ument 448-7
Definition	The entire process should involve the individual as a full partner and should focus on service and recovery analysis as identified by the individual	ibui adt av				and recovery	modilo/sleop /r	יים מים	ytified by	le biyibai edt y	'3
		ם ביים	vidual as	מ ומוו שמו נוופן מוום אווסמור	0 6000 0	ו פפן עוכם מוום ופטטעפו	ı y yoars/outcorr.	ସର ଘର ।ପଟା		y tile illaividadi.	Fi
	Ö	h the courseds;	se of car	e by: stated hopes, choice, pr	eferences	s and desired outcom	ies of the indivic	lual;			led 11/
	 Assuring goals/objectives are related to the assessment; Defining goals/objectives that are individualized specific and measurable with achievable timeframes: 	ire related	to the as	ssessment;	hle with	chievable timeframe					29/
		and desire	d change	s in levels of functioning	and qual	lity of life to objective	الا الا measure pro	jress;			23
		t of service	delivery	/;	- from	doila mooo tood of w	Citocido cocdt	į			P
	7. Selecting services and interventions of the right quantum, interiorly, and hequency to best accomplish triese objectives, 8. Assuring there is a goal/objective that is consistent with the service intent; and	ective that	is consi	stent with the service intensity	ant; and	יץ נט מפשנ מככטוווטוואו	ווופספ ממשפתואי	ί,			'age
		o are resp	onsible	and designated for the p	rovision o	f services.					9 1
Admission Criteria	1. A known or suspected mental illness or substance-related disorder; and 2. Initial screening/intake information indicates a need for additional undete	tal illness r mation ind	or substa licates a	ance-related disorder; a n need for additional unde	id stermined	ed disorder; and additional undetermined supports and recovery/resiliency planning; and	ıry/resiliency pla	nning; an	ъ		67 of
Continuing Stay	ع ا	ning has c	handed	in such a way that previc	Separate Silic	way that previous assessments are outdated					627
Criteria		8	5								

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Service Plan	Service Plan Development	
Discharge Criteria	Each intervention is intended to be a discrete time-limited service that modifies treatment/support goals or is indicated due to change in illness/disorder.	
Service Exclusions	Assertive Community Treatment	_
Required Components	1. The service plan must include elements articulated in the Documentation Guideline chapter in this Provider Manual. 2. As indicated, medical, nursing, peer, school, nutritional, etc. staff can provide information from the individual, records, and various multi-disciplinary resources on needed to complete the service plan. Time spent gathering this information may be billed as long as the detailed documentation justifies the time and need for capturing said information.	ີລຣຣ 1·16
Clinical Operations	er individual-identified natural supports) should actively participate in planning processes. y Plan should be directed by the individual's personal recovery goals as defined by that individual. Planning shall be directed by the individual served and their needs/wishes to the extent possible and clinically appropriate. Plans should onents that are not agreeable to, meaningful for, or realistic for the person and that the person is, therefore, not likely to follow through liliency planning are contained in the DBHDD Requirements for Community Providers in this Provider Manual. ans (or portions of the plan) must be reassessed as needed, in accordance with changing needs, circumstances, and responses of the arding the IRP in Part II of this manual). For any change in medical, behavioral, cognitive, and/or physical status that potentially impacts erventions in the plan, or that would necessitate the addition of new goals, objectives and/or interventions, Service Plan Development ne individual in revisiting their goals and objectives.	6-07-03088-ELD Doc
Service Accessibility	To promote access, providers may use Telemedicine as a tool to provide direct interventions to individuals for whom English is not their first language. Examples of this include: • the use of one-to-one service intervention via Telemedicine, connecting the individual to a practitioner who speaks the individual's language versus use of interpreters; and/or • the use of an interpreter via Telemedicine to support the practitioner in delivering the identified service. Telemedicine may only be utilized when delivering this service to an individual for whom English is not their first language. The individual must consent to the use of the use of telemedicine should be documented in the individual's record. The use of telemedicine should not be driven by the practitioner's/agency's convenience or preference.	Iment ///8-73 Eilor
Billing & Reporting Reporting Requirements Additional Medicaid Requirements	When Telemedicine technology is utilized for the provision of this service in accordance with the allowance in the Service Accessibility section of this definition, the code cited in the Code Detail above with the appropriate GT modifier shall be utilized in documentation and claims submission. The daily maximum within a CSU for combined Behavioral Health Assessment and Service Plan Development is 24 units/day.	d 11/20/22
Documentation Requirements ADULT SPEC	Documentation 1. The initial authorization/IRP and each subsequent authorization/IRP must be completed within the time-period specified by DBHDD. 2. Every record must contain an IRP in accordance with these Service Guidelines and with the DBHDD Requirements contained in this Provider Manual. 4. Every record must contain an IRP in accordance with these Service Guidelines and with the DBHDD Requirements contained in this Provider Manual. 4. Every record must contain an IRP in accordance with these Service Guidelines and with the DBHDD Requirements contained in this Provider Manual. 4. Every record must contain an IRP in accordance with these Service Guidelines and with the DBHDD Requirements contained in this Provider Manual. 4. Every record must contain an IRP in accordance with these Service Guidelines and with the DBHDD Requirements contained in this Provider Manual. 4. Every record must contain an IRP in accordance with these Service Guidelines and with the DBHDD Requirements contained in this Provider Manual. 4. Every record must contain an IRP in accordance with these Service Guidelines and with the DBHDD Requirements contained in this Provider Manual. 4. Every record must contain an IRP in accordance with these Service Guidelines and with the DBHDD Requirements contained in the provider Manual. 5. Every record must contain a provider Manual. 5. Every record must contain a provider Manual. 5. Every record must contain a provider Manual. 6. Every record must contain a provider Manual. 7. Every record must contain a provider Manual. 8. Every record must contain a provider Manual. 8. Every record must contain a provider Manual. 8. Every record must contain a provider Manual. 9. Every record must contain	Page 168 of 627

ADULT SPECIALTY SERVICES

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С	ase	1:16-cv-03088		Docum	ent 448-73	Filed 11/2	29/23	Page 169 of	627
	1 unit	An Addiction Recovery Support Center offers a set of non-clinical, peer-led activities that engage, educate and support individuals and families successfully to make life changes necessary to establish, maintain and enhance recovery (health and wellness) from substance use disorder; and consist of activities that promote recovery, self-determination, self-advocacy, well-being, and independence. Activities are individualized, recovery-focused, and based on a relationship that supports a person's ability to promote their own recovery. Activities include social support, linkage to and coordinating among other service providers, eliminating barriers to independence and continued recovery. Activities may occur in the center or in other locations in the community.	Addiction Recovery Support Services are holistic in nature, support people with moving beyond their substance use disorder and toward a life of self-directed recovery During scheduled hours, Addiction Recovery Support Services may include but are not limited to the following support topics which may occur at a physical location or in the community.	iformed choice.		Providing same to enectively havigate to the health calc delivery such that assist an individual in eliminating barriers to seeking or maintaining recovery, employment, education, or housing; Assisting with accessing and developing natural support systems in the community; Promoting coordination and linkage among similar providers;	Conditioning of assistance in class interventions and stabilization as needed, Conducting community outreach; Attending and participating in recovery planning team; or, Assisting individuals in the development of empowerment skills through self-advocacy and activities that mitigate discrimination and inspire hope.	Non-Clinical Services/Activities ARSCs provide services/activities that are unique to their specific communities. Therefore, not all ARSCs will provide the same activities, nor will they provide them in the same manner. Below is a list of categories of Addiction Recovery Support Services and other activities that may be provided by each ARSC:	gress. May also take the form of telephone, text, and email assertive outreach. or event that is being provided to increase the likelihood that someone in recovery will be employed.
	Maximum Daily Units	ivities that engage, educate and ellness) from substance use distrat promote recovery, self-dete t supports a person's ability to p barriers to independence and c	n moving beyond their substance t are not limited to the following :	Promote self-directed recovery by assisting an individual. Promote trauma informed care and diversity competence, encourage self-direction, and advocate for informed choice. Ongoing exploration of recovery needs;	Supporting individuals in achieving personal independence as identified by the individual; Encouraging hope; Supporting the development of life skills such as budgeting and connecting to community resources; Developing and working toward achievement of personal recovery goals; Modeling personal responsibility for recovery; Transing by the profile to official the official of the book of the open o	in to effectively and efficiently unges or that assist an individual in a community;	eeded, h self-advocacy and activities th	. Therefore, not all ARSCs will p Services and other activities that	scales, or other assessments to assess recovery progress. May also take the form of telephone, text, and email assertive outreach. Employment Services : This can include any activity or event that is being provided to increase the likelihood that someone in reco
		ion-clinical, peer-led act recovery (health and wand consist of activities sed on a relationship tha ce providers, eliminating	ture, support people with Services may include bu	individual. ompetence, encourage s	Supporting individuals in achieving personal independence as identified by the individual; Encouraging hope; Supporting the development of life skills such as budgeting and connecting to community Developing and working toward achievement of personal recovery goals; Modeling personal responsibility for recovery;	Providing ships to effectively having the line inequal care delivery system to effective providing recovery check-in's that allow individuals to address challenges or that as employment, education, or housing; Assisting with accessing and developing natural support systems in the community; Promoting coordination and linkage among similar providers;	is and stabilization as needed, g team; or, powerment skills through self-e	eir specific communities tion Recovery Support 8	ery progress. May also to activity or event that is b
生		s a set of red enhance disorder; disorder; d, and bas other service.	listic in na / Support (ssisting an diversity co	kills such a evement of recovery;	low indivice to the property of the property o	intervenion try plannin nent of em	nique to thess of Addit	ess recove
MH		intain an intain an ance use ance use A-focuse among	s are ho Recovery	ery by as are and overy nee	t of life s ard achi	is that all tousing; a develo	n crisis i each; n recove levelopn	iat are ui categorie	ts to assist
H2001		port Cer blish, ma n a substa recover rdinating	t Service ddiction F	ed recoviormed con	elopmen rking tow responsil	check-in ation, or hashing and and ation and ations is the ation and ations at ations at a	unity outracipating i	tivities the alist of contract	sessment ices: Thi
Addiction Recovery Support Service	lay	An Addiction Recovery Support Center offers a set of non-clin changes necessary to establish, maintain and enhance recovservices for individuals with a substance use disorder; and co Activities are individualized, recovery-focused, and based on support, linkage to and coordinating among other service pro in other locations in the community.	Addiction Recovery Support Services are holistic in nature, s During scheduled hours, Addiction Recovery Support Service in the community.	Promote self-directed recovery by assisting an individual. Promote trauma informed care and diversity competence. Ongoing exploration of recovery needs;	Supporting individuals in achieving personal in Encouraging hope; Supporting the development of life skills such Developing and working toward achievement Modeling personal responsibility for recovery;			Non-Clinical Services/Activities ARSCs provide services/activities the same manner. Below is a list of	scales, or other assessments to assess recovery pro Employment Services: This can include any activity
Addi	1 day	An / char serv Activ supp	Addi: Duri	+. 0, ω,	4. 73. 69. 7. 89. 6	. 17 . 27 . 27	5. 4. 6.	ARS the s	. 4

Service Definition

Rate

Mod

Mod 3

Mod 2

Mod

Code

Code Detail

Rate

Mod Mod 3 4

Mod 2

Mod

Code

Code Detail

Transaction

Code

AD Recovery

Center

Unit Value

Addiction Recovery Support Center – Services (Effective January 1, 2023)

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Addiction K	scovery Support	Addiction Recovery Support Center – Services (Effective January 1, 2023)
	3. Social Support	Social Support Activities: This includes but is not limited to prosocial and other recreational activities such as hikes, group exercises, game nights, movie
		showings, yoga, social outings, etc.
	4. Educational	Educational Services. This section includes any service oriered to support the educational development of someone in recovery in scholastic achievement, such as GED Classes, tutoring, applying for student financial aid for college, applying to college, etc.
	5. Family Supp	Family Support Services: This includes any service specifically targeted towards families of someone in or seeking recovery. Peers may also participate in
	this programn	this programming with or without their family present.
	6. Housing Sup	Housing Supports: Any service that provides, or increases the likelihood of someone in recovery finding, safe living conditions.
		Iransportation supports: Any service trial assists findividuals in or seeking recovery with transportation to/norm supports oriened by the ARSO of to other passimas facilities, againsts, or businesses in the community
	8. Artistic Reco	Artistic Recovery Support: This can include any activity or instruction provided around music, theatre, art, etc. as a supportive outlet for an individual's
		recovery and empowerment.
	9. Volunteering	Volunteering Service: This can be used to track a peer's involvement in volunteering their time to support activities or events conducted by the ARSC.
	Volunteering 10. Recovery Or	Volunteering and giving back are key memes in supporting an individual s continued recovery from substance use disorder. Recovery Oriented Training/Education: This includes an individual's participation in trainings provided by the ARSC such as Recovery Messaging Training, Science of Addition Program, (SOAB), Program of Control Month First Aid and other training are also and other training and other training and other training are also and other training and other training and other training are also and other training and other training are also and other training and other training are also and other training are also and other training and other training are also a
	Adults ages 18 or old	Adults ages 18 or older must meet the following criteria:
	1. The individua	The individual desires to enter or maintain his/her recovery by reducing the recreational use of alcohol or other drugs, reduce participation in illegal activity,
Admission		improve health and wellness, increase participation in healthy social supports.
Criteria	Z. The Individua	I he individual does not need to meet the diagnostic criteria for a Substance Use Disorder as defined in the most recent DSM for the purpose of medical
		ilecessity but iliust ilave a seinlepoi ted ilistory of SOD. The individual regulests support of an alcohol and drug free environment
	4. The individua	The individual can be using Medication Assisted Treatment/Recovery as part of their recovery process and can't be excluded.
Continuing Stay Criteria	The individual continu	The individual continues to attend and participate.
Discharge	1. The individua	
Criteria		The individual fails to follow the guidelines of the ARSC.
Service		The individual exhibits behavior dangerous to staff, self, or others.
Exclusions	2. ARSC start of 3. Drug Abuse 7	ARSC start do not provide clinical services. Drug Abuse Treatment Education Program colocation is prohibited.
		Have a primary goal of enhancing the quantity and quality of support available to individuals seeking recovery from substance use disorders;
		Be grounded in three core principles: a recovery vision, authenticity of voice, and accountability to the recovery community;
	3. Promote the s	
		white nave policies and procedures on now to assist individuals who attend activities while actively intoxicated (use of peer support, connection to services if
Required		individual is willing, etc.). Must be able to provide referrals to other levels of treatment and support for individuals in or seeking recovery.
Components	6. Must have an	Must have an advisory board that meets the following requirements: (1) All members are local to the community, (2) More than 50% identify as being in
		recovery from SUD, (3) must have official board meetings once per month, (4) Must have programmatic decision-making power.
	7. Be responsive	Be responsive to the needs of individuals participating in services and be based on local community needs as identified by the individuals participating in the
	Service.	SERVICE. An individual that only comes to the APSC to attend an AA MA or other anonymous fallowship meating can but is not required to provide identifiable

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ed 11/29/23 Page 171	Rate 21.64	Mod 4 U7	3 Mod U4	Mod H	H H H	Code H0038	Place of Service Code 99 will be used for all claims/encounter submissions to the ASO. rogram Code Mod Mod Mod Mod Rate Code Detail ram, Group Setting, ner Level 4, In-Clinic ram, Group Setting, ner Level 5, In-Clinic ram, Group Setting,	Rate 17.72 13.20	Mod 4 U6	Mod 3 3 U4 U5	Mod HQ HQ	Mod 1 HF HF	Code H0038 H0038	Program Program Code Mod Mod Mod Mod Rate Code Deta String, Group Setting, Grou
48-73	5	efforts c	raising (ngh func	ons thro	al donatic	Visitors that do not meet admission criteria are not to be included in ASO submissions. Must provide DBHDD with an annual calculation of in-kind support (volunteer time, facility donation, etc.) or fiscal donations through fundraising efforts or community collaborations. Community collaborations. Must have a system in place to track unduplicated individuals served for each month.	ASO sul voluntee	cluded in support (als serve	to be infinitional individual	a are not ulation o	on criteria nual calci ack undu	t admissic ith an ann is.	Visitors that do not meet admission criteria are not to be included in ASO submissions Must provide DBHDD with an annual calculation of in-kind support (volunteer time, fa community collaborations. Must have a system in place to track undualicated individuals served for each month.
ment 4						ay.	Any individual that signs in during the hours of operation will be considered supported as a participant for the day. A list of activities that an individual participates in will be tracked. Sign-in sheets and daily activity attendance will be maintained by the ARSC.	sidered s e ARSC	ill be con acked. ned by th	eration will be owill be owill be tracked.	rs of ope bates in v	the hou Il particip ttendanc	in during individua activity a	Any individual that signs in during the hours of operation will be considered s A list of activities that an individual participates in will be tracked. Sign-in sheets and daily activity attendance will be maintained by the ARSC.
.R Docu			isitors.	its and v	articipar	ight for pa	An updated weekly schedule that includes hours of operation, groups, and activities should be posted in plain sight for participants and visitors. Addiction Recovery Support Services are available at any point during the open hours. Recovery activities are offered throughout the day in the center and periodically outside the center, in the community. The individual can utilize this service as support while participating in other treatment services.	os, and a ng the ol periodic n other t	on, group point duri enter and cipating i	of operati e at any p in the ce hile parti	s hours c available t the day upport w	includes ices are oughout	edule that port Servi offered thr this serv	An updated weekly schedule that includes hours of operation, groups, and activities should be Addiction Recovery Support Services are available at any point during the open hours. Recovery activities are offered throughout the day in the center and periodically outside the ce The individual can utilize this service as support while participating in other treatment services.
-EL							RSC is open a minimum of 40 hours per week and is required to have hours consistent with community need.	hours o	d to have	s require	ek and is	s per we	f 40 hours	RSC is open a minimum o
03088	ai	pon hire	iining, u	S-AD tra	fthe CP	onents o	within that twerve (12) from the Ormie. Additional staff may be allowed if approved by DBHDD and needed to support the operations of the center. All staff without CPS-AD designation must participate in a recovery principles orientation, made up of key components of the CPS-AD training, upon hire.	to suppo principle	ineeded ecovery	HDD and ate in a r	d by DB t particip	approve	allowed if designat	Additional staff may be allowed if appliants All staff without CPS-AD designation is
6-cv-	sn	/e" statı	ng "activ	f achievi	station o	the expec	employed by the Addiction Recovery Support Center with the expectation of achieving "active" status	ne Addict	yed by th	Φ	ns of hire ND may I	2) month e CPS-/	twelve (1; al, inactiv	achieved within the first twelve (12) months of hire. With department approval, inactive CPS-AD may be within first trick (12) months of him
e 1:1		I will be	redentia	oS-AD c	at the CF	oups. ctation tha	as Intentional Peer Support, Science of Addiction and Recovery, CPR/First Aid, P-COMS, and All-Recovery Groups. With department approval, an individual with lived experience may be hired as staff with the performance expectation that the CPS-AD credential will be	PR/First / be hired a	overy, CF Ice may k	and Reconstruction	ddiction ith lived	nce of Ar ividual w	oort, Scier al, an indi	as Intentional Peer Supl With department approv
	ng such	of trainir	l areas c	targetec	ouse. pated in	ال. stance Ak ve particiן	An Addiction Recovery Support Center has a full-time Director of day to day operations who is an active CPS-AD. Director of day to day operations attends monthly learning collaboratives convened by Georgia Council on Substance Abuse. The number of remaining staff are defined in contracts but are required to be specially trained CPS-AD who have participated in targeted areas of training such	ly to day trives cor red to be	ctor of da collabora are requi	ime Dire learning acts but	ss a full-t monthly I in contr	enter ha attends i definec	Support C perations a g staff are	An Addiction Recovery : Director of day to day of The number of remainin

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4.

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Requirements

Addiction Recovery Support Center – Services (Effective January 1, 2023)

information for tracking purposes.

The ARSC is open a minimum of 40 hours per week and is required to have hours consistent with community need.

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Documentation

Accessibility

Service

Requirements

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Requirements

Reporting Billing &

AD Peer Su	AD Peer Support Program													
Transaction Code	Code Detail	Code	Mod 1	Mod 2	Mod 3	Mod 4	Rate	ModModRateCode Detail234	Code Mod Mod Mod Rate	Mod 1	Mod 2	Mod 3	Mod 4	Rate
AD Peer	SA Program, Group Setting, Practitioner Level 4, In-Clinic	H0038	生	오	HQ U4 U6		17.72	17.72 SA Program, Group Setting, Practitioner Level 4, Out-of-Clinic	H0038 HF HQ U4 U7 21.64	生	오	40	70	21.64
Services	SA Program, Group Setting, Practitioner Level 5, In-Clinic	H0038 HF	HF	НД	HQ U5 U6	90	13.20	SA Program, Group Setting, Practitioner Level 5, Out-of-Clinic	H0038 HF HQ U5 U7 16.12	生	욧	OLS	U7	16.12
Unit Value	1 hour							Utilization Criteria	OBT					
Service Definition	This service provides structured a wareness and values, and self-determines his or her own way	activities () directed ca	in an ag are. Indi ^x re recov	ency or viduals s	commun served al	ity-base re introdu is occurs	d setting sed to the	This service provides structured activities (in an agency or community-based setting) which promote recovery, self-advocacy, relationship enhancement, self-awareness and values, and self-directed care. Individuals served are introduced to the reality that there are many different pathways to recovery and each individual defermines his or her own way. Supports are recovery oriented. This occurs when individuals share the goal of long-term recovery. Individuals served are encoursed.	ocacy, rela ent pathwa m recover	ntionship ays to re	enhanc ecovery a	ement, s and each	elf- individ	ual
Definition	determines his or her own way. S	Supports a	re recov	/ery orie	nted. Th	is occurs	when in	determines his or her own way. Supports are recovery oriented. This occurs when individuals share the goal of long-term recovery. Individuals served are encouraged	n recover	y. Indi\	> 1	viduals se	viduals served are	viduals served are encour

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	6-cv-03088-E		Documo	ent 448-		Ily during hy max). ducted or desires, d desires, nary team	Page 172 of 6
AD Peer Support Program to initiate and lead group activities and each participant identifies his/her own individual goals for recovery. Activities must promote self-directed recovery by honoring the many pathways to recovery, by tapping into each participant's strengths and by helping each to recognize his/her "recovery capital", the reality that each individual has internal and external resources that they can draw upon to keep them well. Interventions are approached from a lived experience perspective but also are based upon the Science of Addiction Recovery framework. Supportive interactions include motivational interviewing, recovery planning, resource utilization, strengths identification and development, support in considering theories of change, building recovery empowerment and self-efficacy. There is also advocacy support with the individual to have recovery dialogues with their identified natural and formal		- 2	 An adequate continuing care plan has been established; and one or more of the following: Goals of the Individualized Recovery Plan have been substantially met; or Individual served/family requests discharge; or Transfer to another service/level is more clinically appropriate. 	Crisis Stabilization Unit (however, those utilizing transitional beds within a Crisis Stabilization Unit may access this service). Individuals diagnosed with a mental illness that have no co-occurring Substance-Related Disorder.	1. AD Peer Support Program services may operate as a program within a Tier 1 or Tier 2 provider, an Intensive Outpatient Provider (IOP) specialty provider, a WTRS provider or an established peer program.	6. E. 4.R.	← ci
AD Pee	Admission Criteria	Continuing Stay Criteria	Discharge Criteria	Service Exclusions Clinical Exclusions		Required Components	Staffing Requirements

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AD Peer Support Program	port Prog	ram
	5. Service	Services must be provided and/or activities led by staff who are CPS-Ads or other individuals under the supervision of a CPS-AD. A specific activity may be led by
	someor	someone who is not a consumer but is a guest invited by peer leadership.
	6. The ma	The maximum face-to-face ratio cannot be more than 15 individuals to 1 CPS-AD direct service/program staff, based on the average daily attendance in the past
		three (3) months of individuals in the program.
	7. All CPS	All CPS-Ads providing this support must have an understanding of recovery principles as defined by the Substance Abuse Mental Health Services Administration
	and the recover	and the Recovery bill of Rights published by Faces and Volces of Recovery, Inc. and must possess the skills and abilities to assist other individuals in their own recovery processes.
	1. This ser	This service must operate at an established site approved to bill Medicaid for services. However, individuals or group activities may take place offsite in natural
		community settings as appropriate for the individualized Recovery Plan (IRP) developed by each individual with assistance from the program staff.
	2. Individu	Individuals receiving AD Peer Support Program services must demonstrate or express a need for recovery assistance.
		Individuals entering AD Peer Support Program services must have a qualifying diagnosis present in the medical record prior to the initiation of formal clinical
		services. The diagnosis must be given by persons identified in O.C.G.A. Practice Acts as qualified to provide a diagnosis.
	 This ser 	This service may operate in the same building as other day services; however, there must be a distinct separation between services in staffing, program
Olinical		description, and physical space during the hours the Peer Recovery program is in operation except as noted above.
ons	 Adequa 	Adequate space, equipment, turnishings, supplies, and other resources must be provided in order to effectively provide services and so that the program
	מנימוטמרמת	
	6. Staff of	Staff of the AD Peer Support Program must be treated as equal to any other staff of the facility or organization and must be provided equivalent opportunities for
		training (both mandated and offered) and pay and benefits competitive and comparable to the state's peer workforce and based on experience and skill level.
	7. When the	When this service is used in conjunction with Psychosocial Rehabilitation or ACT, documentation must demonstrate careful planning to maximize the
	effective	effectiveness of this service as well as appropriate reduction in service amounts. Utilization of this service in conjunction with these services is subject to review
	8. Each in	Each individual must be provided the opportunity for peer assistance in the form of recovery coaches and allies and community networking to achieve stated
	9. AD Pee	AD Peer Support Programs must offer a range of recovery activities developed and led by consumers, with the recognition of and respect for the fact that there
		are many pathways to recovery.
	10. The pro	The program must have an AD Peer Support Program <i>Organizational Plan</i> addressing the tollowing: a A Recovery Bill of Rights as developed and promoted by Faces and Voices of Recovery Inc. This philosophy must be actively incomposated into all
		services and activities and:
		i. View each individual as the driver of his/her recovery process.
		V. Promote the concepts of employment and education to toster self-determination and career advancement. Vi Cunnert each individual to empress SAMHSA's Description by intilize community resources and education regarding health wellness.
		Support each individual to emplace of wing the factorery in minimum of support each individual to emplace the need for clinical treatment services
		vii. Support each individual to fully participate in communities of their choosing in the environment most supportive of their recovery and that promotes
		housing of his/her choice and to build and support recovery connections and supports within his/her own community.
	4	viii. Actively seek ongoing input into program and service content so as to meet each individual's needs and goals and fosters the recovery process.
		A describitor of the particular consumer empowerment models unitary, types of activities and typical daily activities and scribdule. It offered, means must be described as an adjunctive peer relation building activity rather than as a central activity.

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AD Peer Su	AD Peer Support Program
	for one unit of this service. For instance, if an individual participates in the program from 9-1:15 excluding a 30-minute break for lunch, his/her participating hours
	are 3.75 hours. The rounding policy is applied to the .75 hour and the units billed for that day are 4 units. Practitioner type must still be addressed and so that 4
	units must be adequately assigned to either a U4 or U5 practitioner type as reflected in the log for that day's activities.
	5. A provider shall only record units in which the individual was actively engaged in services. Meals and breaks must not be included in the reporting of units of
	service delivered. Should an individual leave the program or receive other services during the range of documented time in/time out for Peer Support Program
	hours, the absence should be documented on the loa.

AD Peer Sup	AD Peer Support Services – Individual	ual											
Transaction Code	Code Detail	Code	Mod 1	Mod 2	Mod 3	Mod 4	Rate	Code Detail	Code	Mod 1	Mod 2	Mod Mod 3 4	od Rate
	SA Program, Practitioner Level 4, In-Clinic	H0038	生	17	90		20.30	SA Program, Practitioner Level 4, Out-of-Clinic	H0038	HF	U4	U7	24.36
AD Peer Support	SA Program, Practitioner Level 5, In-Clinic	H0038	生	SU.	90		15.13	SA Program, Practitioner Level 5, Out-of-Clinic	H0038	HF	U5	U7	18.15
Services	Practitioner Level 4, Via interactive audio and video telecommunication systems	H0038	GT	ᅫ	U4		20.30	Practitioner Level 5, Via interactive audio and video telecommunication systems	H0038	GT	生	US	15.13
Unit Value	15 minutes							Utilization Criteria	TBD				
o. Goiri	This service provides interventions (in an agency or values, and self-directed care. Individuals served an her own way. Supports are recovery-oriented and or for recovery. Interventions must promote self-directed.	ons (in an Individuals very-orier promote s	agency s served ited and	or comn are intro occur w	nunity-bas oduced to hen indiv	sed settii the real iduals sh	ng) which lity that the grane the granny	This service provides interventions (in an agency or community-based setting) which promote recovery, self-advocacy, relationship enhancement, self-awareness and values, and self-directed care. Individuals served are introduced to the reality that there are many different pathways to recovery and each individual determines his or her own way. Supports are recovery-oriented and occur when individuals share the goal of long-term recovery. Each participant identifies his/her own individual goals for recovery. Interventions must promote self-directed recovery by honoring the many pathways to recovery, by tapping into each participant's strengths and by helping	ationship covery an sipant ider o each pa	enhanc Id each Itifies h Irticipar	sement, individ iis/her o	self-awar ual detern wn indivic ngths and	eness and lines his o ual goals by helping
Definition	each to recognize his/her "recovery capital", the reali Interventions are approached from a lived experience include motivational interviewing, recovery planning, recovery empowerment and self-efficacy. There is al supporters.	very capite om a lived y, recovery f-efficacy.	al", the ra l experie y plannir There is	eality the ince peri ng, resou i also ad	it each in spective t irce utiliza vocacy si	dividual out also i ation, str upport w	has intern are based rengths ide rith the ind	each to recognize his/her "recovery capital", the reality that each individual has internal and external resources that they can draw upon to keep them well. Interventions are approached from a lived experience perspective but also are based upon the Science of Addiction Recovery framework. Supportive interactions include motivational interviewing, recovery planning, resource utilization, strengths identification and development, support in considering theories of change, building recovery empowerment and self-efficacy. There is also advocacy support with the individual to have recovery dialogues with their identified natural and formal supporters.	an draw ul ery frame in consid th their id	pon to P swork. S lering th entified	keep th Suppor heories I natura	em well. ive interad of change I and form	tions , building al
Admission Criteria	Individual must have a substance related issue; and one or more of the following : a. Individual needs peer-based recovery support for the acquisition of skills needed to engab. Individual needs assistance to develop self-advocacy skills to achieve decreased depence. Individual needs assistance and support to prepare for a successful work experience; or d. Individual needs peer modeling to increased responsibilities for his /her own recovery.	stance rela based reca ance to de ance and nodeling to	ated issue overy sue sycelop se support or increase	Le; and cont for the poort for elf-advorted to prepared sed resp	one or many the acquator skills for a since for a sinc	ore of the distinction of the achievant	and one or more of the following: ort for the acquisition of skills neede-advocacy skills to achieve decrease prepare for a successful work experd responsibilities for his /her own rec	ndividual must have a substance related issue; and one or more of the following : a. Individual needs peer-based recovery support for the acquisition of skills needed to engage in and maintain recovery; or b. Individual needs assistance to develop self-advocacy skills to achieve decreased dependency on formalized treatment systems; or c. Individual needs assistance and support to prepare for a successful work experience; or d. Individual needs peer modeling to increased responsibilities for his /her own recovery.	ery; or ment syst	ems; o	ت		
Continuing Stay Criteria	 Individual continues to meet admission criteria; and Progress notes document progress relative to goals 	admission ogress re	n criteris lative to	t; and goals id	entified in	the Indi	ividualizec	Individual continues to meet admission criteria; and Progress notes document progress relative to goals identified in the Individualized Recover Plan, but treatment/recovery goals have not yet been achieved	ry goals h	ave no	t yet be	en achiev	∋d.
Discharge Criteria	 An adequate continuing care plan has been established; and one or more of the following: Goals of the Individualized Recovery Plan have been substantially met; or Individual served/family requests discharge; or Transfer to another service/level is more clinically appropriate. 	e plan hat Recovery uests disc level is mo	s been e Plan hav harge; c ore clinic	stablisheve been or ne	iblished; and one or more been substantially met; or ly appropriate.	ne or m ally met;	ore of the	e following:					
Service Exclusions	Crisis Stabilization Unit (howeve	ır, those u	tilizing tı	ansition	al beds w	ithin a C	Crisis Stab	Crisis Stabilization Unit (however, those utilizing transitional beds within a Crisis Stabilization Unit may access this service).					

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AD Peer Sup	<u> </u>	
	vii. Support each individual to fully participate in communities of their choosing in the environment most supportive of their recovery and that promotes nousing of his/her choice and to build and support recovery connections and supports within his/her own community. viii. Actively seek ongoing input into program and service content so as to meet each individual's needs and goals and fosters the recovery process. b. A description of the particular consumer empowerment models utilized, types of activities offered, and typical daily activities and schedule. If offered, meals must	Case
	be described as an adjunctive peer relation building activity rather than as a central activity. A description of the staffing pattern plans for staff who have or will have CPS and appropriate credentials, and how staff are deployed to assure that the required staff-to-individual ratios are maintained, including how unplanned staff absences, illnesses, and emergencies are accommodated.	1:16-cv
	opportunities to meet with or otherwise receive support from other peers both within and outside the red to seek Georgia certification as CPS-AD through participation in training opportunities and peer	/-03088
	or other counseling regarding anxiety following certaincation. 1. A description of test-taking skills and strategies, assistance with study skills. Information about training and testing opportunities to hear from and interact with peers who are already certified, additional opportunities for peer staff to participate in clinical team meetings at the request of a participant, and the	-ELR
	d the types of services and activities provided for and by individuals served, as well as for families,	Dod
Clinical Operations,	n's decision-making processes, including how participants' direct decision-making about both individual and program-wide activities dispute resolution processes.	cumei
continued	A description of how individuals participating in the service at any given time are given the opportunity to participate in and make decisions about the activities that are conducted or services offered within the Peer Recovery program, about the schedule of those activities and services, and other operational issues. A description of the materials, supplies, transportation, and other resources available for individuals participating in the Peer Recovery services.	nt 448-7
	A description of the governing body and /or advisory structures indicating how this body/structure meets requirements for peer leadership and cultural diversity. A description of how the plan for services and activities is modified or adjusted to meet the needs specified in IRP.	' 3
	 m. A description of how individual requests for discharge and change in service or service intensity are handled; and n. Assistive tools, technologies, worksheets, (e.g., SOAR; Recovery Check-Ins; Motivational Interviewing; Cultural Competence, Stigma & Labeling etc.) can be used by the Peer Recovery staff to work with the served individual to improve his/her communication about treatment, symptoms, improvements, etc. with treating behavioral health and medical practitioners. 	Filed 11
	tool to provide direct interventions to individuals for whom English is not their first language. Examples of this	/29/2
Service Accessibility	 the use of one-to-one service intervention via Telemedicine, connecting the individual to a practitioner who speaks the individual's language versus use of interpreters; and/or the use of an interpreter via Telemedicine to support the practitioner in delivering the identified service. 	.3 Pag
	Telemedicine may only be utilized when delivering this service to an individual for whom English is not their first language. The individual must consent to the use of telemedicine should not be driven by the practitioner's/agency's convenience or preference.	je 177 o
Documentation Requirements	nust document services in accordance with the specifications for documentation requirements in Part II, Section III of the Provider Manual.	of 627

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AD Peer Support Services – Individual

Reporting

When Telemedicine technology is utilized for the provision of this service in accordance with the allowance in the Service Accessibility section of this definition, the code cited in the Code Detail above with the appropriate GT modifier shall be utilized in documentation and claims submission. Requirements

Ambulatory	Ambulatory Substance Abuse Detoxification	kificati	uq										
Transaction Code	Code Detail	Code	Mod 1	Mod 2	Mod 3	Mod 4	Rate	Code Detail	Code	Mod 1	Mod 2	Mod Mod 3 4	d Rate
Alcohol and/or Drug Services;	Practitioner Level 2, In-Clinic	H0014	U2	90			38.97	Practitioner Level 4, In-Clinic	H0014 1	U4	9N		20.30
Ambulatory Detoxification	Practitioner Level 3, In-Clinic	H0014	U3	90			30.01						
Unit Value	15 minutes							Utilization Criteria	TBD				
Service Definition	This service is the medical monitoring of the physical level of readiness for behavioral change and level of withdrawal, but life or significant bodily functions are This service must reflect ASAM (American Society of with Extended Onsite Monitoring) and focuses on rap criteria. These services may be provided in traditiona	toring of t change a bodily fur (Americar) and foci	the physiand level arctions a rections a Society uses on in tradition	ical proce of commine not the not the very Addington trapid standorth out	process of with community/soc not threatened addiction Mec id stabilization I Outpatient, In I I I I I I I I I I I I I I I I I I	thdrawa cial supl I. dication) and en	I from alcoport. It is in Levels 1-1 try into the Outpatient	This service is the medical monitoring of the physical process of withdrawal from alcohol or other drugs in an outpatient setting for those individuals with an appropriate level of readiness for behavioral change and level of community/social support. It is indicated when the individual experiences physiological dysfunction during withdrawal, but life or significant bodily functions are not threatened. This service must reflect ASAM (American Society of Addiction Medication) Levels 1-WM (Ambulatory Without Extended On-Site Monitoring) and 2-WM (Ambulatory with Extended Onsite Monitoring) and focuses on rapid stabilization and entry into the appropriate level of care/treatment based upon the ASAM guidelines placement criteria. These services may be provided in traditional Outpatient, Intensive Outpatient, Intensive Day Treatment or other ambulatory settings.	ting for the ses physio n-Site Mor ased upon ment or of	use ind logical logical nitoring the Astronauther arr	ividuals dysfund dysfund) and 2 SAM gu	with an a stion durin durin durin durin durin durin durin stidelines py settings	ppropriate g
Admission Criteria	Individual has a Substance Related Disorder (ASAM PPC-2, Dimension-1) that is incapacitating, destabili be sufficient optimization in other dimensions of the individual's life to provide for safe withdrawal manage following three criteria: 1. Individual is experiencing signs and symptoms of withdrawal, or there is evidence (based on history of present symptoms, physical condition, and/or emotional/behavioral condition) that withdrawal is immi WM) to moderate (Level 2-WM) risk of severe withdrawal syndrome outside the program setting and 2. Individual has no incapacitating physical or psychiatric complications that would preclude ambulatory 3. Individual is assessed as likely to complete needed withdrawal management and to enter into continual Individual has adequate understanding of and expressed interest to enter into ambulatory detoxis continual has adequate support services to ensure commitment to completion of withdrawal made. Individual evidences a willingness to accept recommendations for treatment once withdrawal has	ted Disor r dimensions and son general condition (VM) risk conting physically to contrained by understable support willingnes	der (AS/ons of tt symptor , and/or of severe ical or p: mplete n early und anding o services	AM PPC- ne individ ns of with emotion sychiatric eeded wi erstand if and ext if on ensu	2, Dimerual's life drawal, cal/behav wal synd complicithdrawal and are a pressed in comm	sion-1) to provious there ional cor rome ou ations the manage able to from recest if the manage able to for ions for ions for ions for ions for the provious for ions for interest in the provious for interest in the prov	that is ince de for safe is evidence rdition) tha rtside the p hat would p ement and allow instru to enter int to completic treatment	ndividual has a Substance Related Disorder (ASAM PPC-2, Dimension-1) that is incapacitating, destabilizing or distressing. If the severity is incapacitating, there must e sufficient optimization in other dimensions of the individual's life to provide for safe withdrawal management in an outpatient setting, and individual meets the billowing three criteria: 1. Individual is experiencing signs and symptoms of withdrawal, or there is evidence (based on history of substance intake, age, gender, previous withdrawal history, present symptoms, physical condition, and/or emotional/behavioral condition) that withdrawal is imminent; and the individual is assessed to be at minimal (Level 1-WM) to moderate (Level 2-WM) risk of severe withdrawal syndrome outside the program setting and can safely be managed at this service level; and MM) to moderate (Level 2-WM) risk of severe withdrawal management and to enter into continued treatment or self-help recovery as evidenced by: 2. Individual has no incapacitating physical or psychiatric complications that would preclude ambulatory detoxification services; and 3. Individual las sasessed as likely to complete needed withdrawal management and to enter into ambulatory detoxification services; or 4. Individual has adequate understanding of and expressed interest to enter into ambulatory detoxification services; or 5. Individual has adequate support services to ensure commitment to completion of withdrawal management and entry into ongoing treatment or recovery; or 6. Individual evidences a willingness to accept recommendations for treatment once withdrawal has been managed.	j. If the serient settin settin settin se, age, ge vidual is a vices; and vices; and vices; or self-help re try into ong	verity is g, and inder, p ssesse his sen his sen t covery	s incapa individu revious d to be vice lev ras evir reatmer	acitating, t al meets i withdraw at minima at minima el; and lenced by	the anust the all history, I (Level 1-
Continuing Stay Criteria	Individual's withdrawal signs and symptoms are not need for further medical or withdrawal management	symptor rawal ma	ns are n nageme		ently resc pring.	olved so	that the in	sufficiently resolved so that the individual can participate in self-directed recovery or ongoing treatment without the monitoring.	d recovery	or on	joing tre	eatment w	ithout the
Discharge Criteria	 Adequate continuing care plan has been established; and one or more of the following: Goals of the Individualized Recovery Plan have been substantially met; or Individual/family requests discharge and individual is not imminently dangerous; or Withdrawal signs and symptoms have failed to respond to treatment and have intensifie standardized scoring system) such that transfer to a more intensive level of withdrawal 	in has bet ecovery F charge ar ims have such tha	en estab Plan have nd indivic failed to it transfe	lished; a e been sı Jual is nc respond	nd one o ubstantia ot immine to treatr	r more cally met; sutly dar nent and sive leve	of the follovor or igerous; or it have inte	Adequate continuing care plan has been established; and one or more of the following: Goals of the Individualized Recovery Plan have been substantially met; or Individual/family requests discharge and individual is not imminently dangerous; or Withdrawal signs and symptoms have failed to respond to treatment and have intensified (as confirmed by higher scores on CIWA-Ar or other comparable standardized scoring system) such that transfer to a more intensive level of withdrawal management service is indicated; or	s on CIWA i; or	۱-Ar or	other co	omparable	

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m rd}$ Quarter Provider Manual for Community Behavioral Health Providers (January 1, 2023)

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(Cas	se 1:16	-C\	v-0	308	8-EL	.R	Docu	ment	44	8-73	Fi	led 1	.1/29	/23	Pa	ige 1	.79 o	f 627
	tion).	tential is			ce Act of cation	urs or the	ting, as	ing to			Rate	\$32.46	\$32.46	\$32.46	\$32.46	\$32.46	\$6.60	\$4.43	\$3.30
	ministra	apse por			al Practi detoxifi	124 אסו 24	the set	and trair			Mod 4			'					
	ition Adi	n 4, rela	S.	:	MedicalMatory	m within	termine	euicatio			Mod 3						U7	U7	U2
-	Medica	imensio	ncycline	:	nt to the ate amb	igns the	e will de	dall cour			Mod 2	10	10	10	70	70	U3	104	U5
	ately as	SAM D	nd phei		pursua d to initi	sician s	service	y not re I individ			Mod 1	J	U2	U3	U4	U5	오	9	g
	led separa	ent as in A	inogens a	, 290-4-2.	dical staff is require	d the phy	taff for the	group and			Code	H0039	H0039	H0039	H0039	H0039	H0039	H0039	H0039
	ACT, Nursing and Medication Administration (Medication administered as a part of Ambulatory Detoxification is not billed separately as Medication Administration).	in all aspects of daily living, there is resistance to treatment as in ASAM Dimension 4, relapse potential is or (Dimension 6). ealth issues warrant inpatient/residential treatment.	This service code does not cover withdrawal management treatment for cannabis, amphetamines, cocaine, hallucinogens and phencyclines.	es and Regulations for Drug Abuse Treatment Programs, 290-4-2	I here must be a written service order for Ambulatory Detoxitication and must be completed by members of the medical staff pursuant to the Medical Practice Act of 2009, Subsection 43-34-23 Delegation of Authority to Nurse and Physician Assistant and in the individual's record is required to initiate ambulatory detoxification	services. Verbal orders or those initiated by other appropriate members of the medical staff are acceptable provided the physician signs them within 24 hours or the next working day.	is needed, and the authorization of appropriate medical staff for the service will determine the setting, as	wer as the annount of musing and physician supervision necessary during the withdrawarprocess. The individual may be made medication, and 24-hour nursing services are not required. However, there is a contingency plan for "after hours" concerns/emergencies. In order for this service to have best practice impact, the Individualized Recovery/Resiliency Plan should consider group and individual counseling and training to			Code Detail	Practitioner Level 1, Out-of- Clinic	Practitioner Level 2, Out-of- Clinic	Practitioner Level 3, Out-of- Clinic	Practitioner Level 4, Out-of- Clinic	Practitioner Level 5, Out-of- Clinic	Practitioner Level 3, Group, Out-of-Clinic	Practitioner Level 4, Group, Out-of-Clinic	Practitioner Level 5, Group Out-of-Clinic
	a part of Ar	of daily livi 6). arrant inpe	ır cannabis	ations for [l must be c ian Assista	of the me	d the autho	ing une wiu for "after h Recovery/I			Rate	\$32.46	\$32.46	\$32.46	\$32.46	\$32.46	\$6.60	\$4.43	\$3.30
	red as	aspects nension ssues w	tment fo	d Regul	tion and d Physic	embers	ded, an	naly duni ncy plan ualized			Mod 4								
	dministe		ent trea	kules an	etoxifica urse and	priate m	orts nee	ontinger ontinger ontinider			Mod 3						90	90	90
	ication a	individu nent is p havioral	anagem	der the F	latory D	er appro	of supp	pervision are is a c ipact, the			Mod 2	90	90	90	90	90	U3	U4	US
	on (Med	ated the environr other be	drawal m	HFR un	or Ambu of Autho	d by oth	ns, level	ever, the actice in			Mod 1	1 1	U2	U3	U4	US	오	오	Я
	dministrati	incapacit recovery on and/or	over withou	by DCH/	ice order t Jelegation	ose initiate	's symptor	gand priys lired. How ve best pr			Code	H0039	H0039	H0039	H0039	H0039	H0039	H0039	H0039
	ACI, Nursing and Medication Ac	 Substance Use Disorder has incapacitated the individual in all aspects of daily living, there is resistance to the high (Dimension 5), and the recovery environment is poor (Dimension 6). Concomitant medical condition and/or other behavioral health issues warrant inpatient/residential treatment. 		— I	 I here must be a written servi 2009, Subsection 43-34-23 D 	services. Verbal orders or the next working day.	1. The severity of the individual's symptoms, level of support	nursing services are not required. However, there is a col 2. In order for this service to have best practice impact, the	any support recovery.	ommunity Treatment		Practitioner Level 1, In-Clinic	Practitioner Level 2, In-Clinic	Practitioner Level 3, In-Clinic	Practitioner Level 4, In-Clinic	Practitioner Level 5, In-Clinic	Practitioner Level 3, Group, In- Clinic	Practitioner Level 4, Group, In- Clinic	Practitioner Level 5, Group, In- Clinic

Components

Required

Exclusions

Clinical

Exclusions

Service

Operations

Clinical

Individual has been unable to complete Level 1-WM/2-WM despite an adequate trial.

Ambulatory Substance Abuse Detoxification

Assertive Community Treatment	atment											
Code Detail Code Mod		Mod 1	Mod 2	Mod N	Mod 4	Rate	Code Detail	Code	Mod 1	Mod 2	Mod Mod 3 4	Rate
Practitioner Level 1, In-Clinic H0039 U1	Н0039 U1	U1	9N		07	\$32.46	Practitioner Level 1, Out-of- Clinic	H0039	U1	U7		\$32.46
Practitioner Level 2, In-Clinic H0039 U2		U2	ne		0,7	\$32.46	Practitioner Level 2, Out-of- Clinic	H0039	U2	U7		\$32.46
Practitioner Level 3, In-Clinic H0039 U3		U3	ne		0,7	\$32.46	Practitioner Level 3, Out-of- Clinic	H0039 U3		70		\$32.46
Practitioner Level 4, In-Clinic H0039 U4		U4	ne		0,7	\$32.46	Practitioner Level 4, Out-of- Clinic	H0039	U4	U7		\$32.46
Practitioner Level 5, In-Clinic H0039 U5		U5	9N		0,7	\$32.46	Practitioner Level 5, Out-of- Clinic	H0039	O15	U7		\$32.46
Practitioner Level 3, Group, In- H0039 HQ Clinic		HQ	U3	9N	97	\$6.60	Practitioner Level 3, Group, Out-of-Clinic	H0039	HQ	U3	U7	\$6.60
Practitioner Level 4, Group, In- Clinic		HQ	U4	9N	0,7	\$4.43	Practitioner Level 4, Group, Out-of-Clinic	H0039	Я	U4	U7	\$4.43
Practitioner Level 5, Group, In- H0039 HQ Clinic		Й	 U5	90	0,7	\$3.30	Practitioner Level 5, Group Out-of-Clinic	H0039 HQ U5	Й	U5	U7	\$3.30

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2	1							
	00001	F	<u> </u>		07			C
	H0038	_ 5	70		\$32.40			ase
						Utilization Criteria TBD		1:
	ACT is an Evidence Based Practice that is person-centered, pagestant mental illness. The individual's mental illness has	person-	centered,	recovery-orien	ited, and a	ACT is an Evidence Based Practice that is person-centered, recovery-oriented, and a highly intensive community-based service for individuals who have serious and presistent mental illness. The individual's mental illness has significantly innaired his or her functioning in the community. ACT provides a variety of interventions	pur	:16-
	ays a week	The se	rvice utilizion: additi	res a multidisci	plinary me	twenty-four (24) hours, seven days a week. The service utilizes a multidisciplinary mental health team from the fields of psychiatry nursing, psychology, social work, substance use disorders, and vocational rehabilitation; additionally, a Certified Peer Specialist is an active member of the ACT Team providing assistance with the	<u>ــــــــــــــــــــــــــــــــــــ</u>	cv-03
22	, promotin	g socializ	zation, an	d the strengthe	ning of cor	development of natural supports, promoting socialization, and the strengthening of community living skills. The ACT Team works as one organizational unit providing	ing	808
ജ	community-based interventions that are rehabilitative, intensi and the active involvement in assisting individuals to achieve	habilitativ ividuals t	ve, intensi o achieve	ive, integrated, a stable and s	and stage	community-based interventions that are rehabilitative, intensive, integrated, and stage specific. Services emphasize social inclusiveness though relationship building and the active involvement in assisting individuals to achieve a stable and structured lifestyle. The service providers must develop programmatic goals that clearly	- Bu	8-El
8	ce-based p	oractices	for ACT r	ecipients using	g co-occum	articulate the use of best/evidence-based practices for ACT recipients using co-occurring and trauma-informed service delivery and support. Practitioners of this		.R
ä ä	knowledg ו Ith service	je and sk is are dire	cills accord	ding to the currided internally	ent resear bv the AC ⁻	service are expected to maintain knowledge and skills according to the current research trends in best/evidence-based practices. ACT is a unique treatment model i which the maiority of mental health services are directly provided internally by the ACT program in the recipient's natural environment. ACT services are individually	.⊑ .≥	D
0 a	ddress his	/her pref	erences a	tailored with each individual to address his/her preferences and identified goals, which are the the individual, services may include (in addition to those services provided by other systems):	oals, which	tailored with each individual to address his/her preferences and identified goals, which are the basis of the Individualized Recovery Plan (IRP). Based on the needs of the individual services may include (in addition to those services provided by other systems):	s of	ocur
je.	individual	s active	participati	Assistance to facilitate the individual's active participation in the development of the IRP;	opment of	the IRP;		ner
.⊑ 7	strumenta	Support	to individ	Psycho educational and instrumental support to individuals and their identified family,	dentified fa	imily;		nt 4
ss I tar	Crisis pianning, wellness Recovery Action Plan (WRA) Psychiatric assessment and care; nursing assessment	Action PI. Irsing ass	an (WKAI sessment	A), assessmentand care; psyc	t, suppoπ a chosocial a	orisis pianning, weilness Recovery Action Plan (WRAP), assessment, support and intervention; Psychiatric assessment and care; nursing assessment and care; psychosocial and functional assessment which includes identification of strengths, skills,		148-
								73
ت 2. ط	Curriculum-based group treatment; Individualized interventions, which may include:	or loci ve	<u>.</u>					
₹	e individue	ત્રી, of barr	iers that i	mpede the dev	elopment	dentification, with the individual, of barriers that impede the development of skills necessary for independent functioning in the community; as well as		File
₹	nich may a	id the inc	dividual in	existing strengths which may aid the individual in recovery and goal achievement;	goal achiev	/ement;		d í
<u></u>	Support to facilitate recovery (including emotional/therapeu	ncluding	emotiona	//therapeutic su	upport/assi	/therapeutic support/assistance with defining what recovery means to the individual in order to assist		11/2
S S	e coordina	tion to as	ssist the ir	رباباناتاتاتاتاتاتاتاتاتاتاتات ndividual with t	he acquisit	nativated with recovery based year setting and attention,, Service and resource coordination to assist the individual with the acquisition and maintenance of recovery capital (i.e. gaining access to necessary internal	ernal	29/2
abili	tative, mec	dical and	other ser	vices) required	l for recove	and external rehabilitative, medical and other services) required for recovery initiation and self-maintenance;		23
g/tr	aining for i	ndividual	s and the	ir families (as r	elated to the	Family counseling/training for individuals and their families (as related to the person's IRP);		
s yelo	op both me	ntal illne	ss and ph	ysical health s	ymptom m	Assistance to develop both mental illness and physical health symptom monitoring and illness self-management skills in order to identify and minimize the	the	Pa
or s mot	negative enects or symptoms wnich interrere with self- medication motivation and skills) and to pron	vnich inte I skills) a	errere with nd to pror	negative effects of symptoms which interfere with the individual self-medication motivation and skills) and to promote wellness:	s dalily livir	i the Individual's daily living (may include medication administration and/or observation and assistance with note wellness;	MITH 6	ge
300	ssing enti	tlement k	oenefits ar	nd financial ma	ınagement	Assistance with accessing entitlement benefits and financial management skill development;		18
istar	nce to deve	∋lop and	work on g	joals related to	personal	Motivational assistance to develop and work on goals related to personal development and school or work performance;		0 c
isor	der couns	eling anc	l intervent	ion (e.g. motiva	ational inte	Substance use disorder counseling and intervention (e.g. motivational interviewing, stage-based interventions, refusal skill development, cognitive		f 6
3,'	osycho edu	ucational	approact	nes, instrument	al support	behavioral therapy, psycho educational approaches, instrumental support such as helping individual relocate away from friends/neighbors who influence	e e	27
b	evention p	lanning e	and techni	drug use, relapse prevention planning and techniques etc.);				7

Definition Service

\$0.00

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H0039

Multidisciplinary Team Meeting

\$32.46

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H0039

telecommunication systems

interactive audio and video

Practitioner Level 1, Via

Assertive Community Treatment

Unit Value

Service and resource coordination to assist the individual with the acquisition and maintenance of recovery capital (i.e. gaining acces: negative effects of symptoms which interfere with the individual's daily living (may include medication administration and/or observation Assistance to develop both mental illness and physical health symptom monitoring and illness self-management skills in order to iden Identification, with the individual, of barriers that impede the development of skills necessary for independent functioning in the comm Support to facilitate recovery (including emotional/therapeutic support/assistance with defining what recovery means to the individual Motivational assistance to develop and work on goals related to personal development and school or work performance; and external rehabilitative, medical and other services) required for recovery initiation and self-maintenance; Assistance with accessing entitlement benefits and financial management skill development; Family counseling/training for individuals and their families (as related to the person's IRP); existing strengths which may aid the individual in recovery and goal achievement; self-medication motivation and skills) and to promote wellness; individual with recovery-based goal setting and attainment); ന് Ю. ပ e e . 9

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It individualized, a rectoring on the borone psychococal relabilishment and sell development including assistance on the borone psychococal relabilishment and sell development including a property and functional site. It advantages to the property and transforms that is a community per
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Case 1:16-cv-03088-ELR

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Assertive Community Treatment	nmur	ity Treatment
	o.	Individual requests discharge and is not in imminent danger of harm to self or others; or
	6	Transfer to another service/level of care is warranted by a change in individual's condition; or
		Individual requires services not available in this level of care.
	1. AC	ACT is a comprehensive team intervention and most services are excluded, with the exceptions of:
	æ.	Peer Supports;
	р.	Residential Supports;
	ပ	Community Transition Planning (to be utilized as a person is transitioning to/from an inpatient setting, jail, or CSP);
	þ.	Group Training/Counseling (within parameters listed in Section A);
	aj.	Supported Employment;
	÷	Psychosocial Rehabilitation - Group;
	Ö	SA Intensive Outpatient (If a substance use disorder is identified and documented as a clinical need unable to be met by the ACT team Substance Abuse
		counselor, and the individual's current treatment progress indicates that provision of ACT services alone, without an organized SA-program model, is not likely
		to result in the individual's ability to maintain sobriety ACT teams may assist the individual in accessing this service, but must ensure clinical coordination in
		order to avoid duplication of services. If ACT and SAIOP are provided by the same agency, the agency may update the existing authorization to include group
		Services to be utilized by the SAIOP program;
	<u>.</u>	Group therapy is not a service exclusion when the needs of an individual exceed that which can be provided by the ACT team, the individual may participate
		in SA group treatment provided by a Tier 1 or Tier 2 provider or SA-IOP provider upon documentation of the demonstrated need.
	. <u>-</u> :	Specialized evidence-based practices are not service exclusions (excluded) when the needs of an individual exceed that which can be provided by the ACT
Corrigo		
Exclusions		Individual's recovery plan (IRP) must reflect the necessity for participation in such services along with medical record documentation of the unique need and
ראכומפוסו		resulting collaboration between service providers to ensure coordination towards goals and to prevent any duplication of services/effort; and
		High Utilization Management.
	2. On	On an individual basis, up to eight (8) weeks of some services may be provided to ACT consumers to facilitate a smooth transition from ACT to these other
	COD	community services. A transition plan must be adequately documented in the IRP and clinical record. These services are:
	æ.	Case Management/Intensive Case Management.
	р.	Psychosocial Rehabilitation Individual/Group.
	ပ	AD Support Services.
	Ь.	Behavioral Health Assessment.
	œ.	Service Plan Development.
	<u></u>	Diagnostic Assessment.
	ö	Physician Assessment (specific to engagement only).
	۲.	Individual Counseling (specific to engagement only).
	3. AC	ACT recipients who also receive a DBHDD Residential Service may not receive ACT-provided skills training which is a part of the "residential" service. The ACT
	pro	provider shall be in close coordination with the Residential provider such that there is no duplication of services supports/efforts.
,	4. Tho	Those receiving Medicaid I/DD Waivers who meet the admission criteria above may be considered for this service as long as his/her waiver service plan is not so
	con	comprehensive in nature as to be duplicative to the ACT service scope.
	- Indi	Individuals with the following conditions are excluded from admission unless there is clearly documented evidence of a psychiatric condition/substance use
		disorder co-occurring with one of the following diagnoses: Developmental Disability, Autism, Neurocognitive Disorder, Substance-Related Disorder.
Exclusions	2. Indi	Individuals may be excluded if there is evidence that they are unable to participate in the development of their Individual Recovery Plan as a result of significant
		impairment due to an <i>I/DL</i> diagnosis.

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Assertive Community Treatment

- Assertive Community Treatment must include a comprehensive and integrated set of medical and psychosocial services provided in non-office settings 80% of the time by a mobile multidisciplinary team. The team must provide community support services interwoven with treatment and rehabilitative services and regularly scheduled team meetings which will be documented in the served individual's medical record.
- Documentation Requirements section below. Each individual must be discussed, even if briefly, in each Treatment Team Meeting. The Treatment Team Meetings Ideally, and in accordance with the Dartmouth Assertive Community Treatment Scale (DACTS), the Treatment Team meeting must be held a minimum of 4 times ACT team members are expected to attend; exception of nonattendance can be made and documented by the Team Leader. The psychiatrist must participate at are to review the status of all individuals and the outcome of the most recent staff contacts, develop a master staff work schedule for the day's activities, and all a week with time dedicated to discussion of support to a specific individual, and documentation in the log of the Treatment Team Meetings as indicated in the east one time/week in the ACT team meetings. ςi
- Each ACT team will identify an Individual Treatment Team (ITT) for each enrolled ACT individual.
- completion of the housing need and choice survey (https://dbhddapps.dbhdd.ga.gov/NSH/) upon admission and with the development of a housing goal, which will individuals will be provided assistance by the ACT team with gaining skills and resources necessary to obtain housing of the individual's choice, including be minimally updated at each reauthorization. დ. 4<u>.</u>
- Services and interventions must be individually tailored to the needs, goals, preferences and assets of the individual with the goals of maximizing independence and recovery as defined by the individual. 5.
- At least 80% of all service units must involve face-to-face contact with individuals. Eighty percent (80%) or more of face-to-face service units must be provided outside of program offices in locations that are comfortable and convenient for individuals (including the individual's home, based on individual need and preference and clinical appropriateness). .
- to achieve fidelity with the DACTS Model. To achieve a score of "4" in the Frequency of Contact Measure within DACTS, ACT Teams must provide a median of 3-During the course of ACT service delivery, the ACT Team will provide the intensity and frequency of service needed for each individual. ACT teams are expected face-to-face contacts of each individual in the sample. At least one of these monthly contacts must include symptom assessment/management and management 3.99 face-to-face contacts per week across a sample of agency's ACT individuals. This measure is calculated by determining the median of the average weekly ۲.

Components

- these individuals participating in ACT transitioning must receive a minimum of 4 face-to-face contacts per month during the documented active transition period. During discharge transition, the number of face-to-face visits per week will be determined based on the person's mental health acuity with the expectation that ω.
 - Service may be delivered by a single team member to 2 ACT individuals at the same time if their goals are compatible, however, this cannot be a standard practice. Services cannot be offered to more than 2 individuals at a time (exception: Item A.8.) _ග්
- Behavioral Therapy (DBT), Motivational Enhancement, Integrative Dual Diagnosis Treatment (IDDT), etc. For this to be allowable, the ACT participants must have ACT recipients can receive limited Group Training/Counseling (up to 20 units/week) when a curriculum-based therapeutic group is offered such as Dialectical clinical needs and recovery goals that justify intervention by staff trained in the implementation of the specific curriculum-based therapy. 9
- This group may be offered to no less than 3 individuals and no more than 10 ACT participants at one time. æ.
 - Only ACT enrolled individuals are permitted to attend these group services.
- Acceptable group practitioners are those on the ACT team who meet the practitioner levels as follows:
 - Practitioner Level 1: Physician/Psychiatrist.
- Practitioner Level 2: Psychologist, CNS-PMH.
- Practitioner Level 3: LCSW, LPC, LMFT, and RN. In addition, and only performing these functions related to the treatment of substance use disorders: MAC, CAADC, GCADC-II or -III, and CAC-II.
- Practitioner Level 4: LMSW, APC, AMFT, and Psychologist/LCSW/LPC/LMFT's supervisee/trainee with at least a Bachelor's Degree in one of the practice acts of the state. In addition, and only performing these functions related to the treatment of substance use disorders: GCADC-I (with helping professions such as social work, community counseling, counseling, psychology, or criminology, functioning within the scope of the .≥

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Assertive Community Treatment

- The psychiatrist (including Physician Extender) to ACT individual ratio must not be greater than 1:100. Specifically:
- With 1-50 consumers, the requirement for the ACT team is to employ a Psychiatrist/Physician Extender minimally .35-.5 FTE (14 hrs./wk-20
- With 51-65 consumers, the requirement for the ACT team is to employ a Psychiatrist/Physician Extender minimally .36-.65 FTE (14.4 hrs./wk-26 hrs./wk.) providing support to the team and;
- With 66-75 consumers, the requirement for the ACT team is to employ a Psychiatrist/Physician Extender t minimally .47-.75 FTE (18.8 hrs./wk-30 hrs./wk.) providing support to the team; and
 - With 76-100 consumers, the requirement for the ACT team is to employ a Psychiatrist/Physician Extender minimally .54 FTE-1 FTE (21.6 hrs. /wk-40 hrs./wk.) providing support to the team.
- Feams utilizing a physician extender (APRN, NP, or PA) for part of the Psychiatrist time outlined above must maintain enough Psychiatrist time not including physician extenders) to obtain a score of at least 3 on the DACTs on the Psychiatrist staffing item (.40FTE Psychiatrist per 100 consumers) on the DACTS. The physician extender's FTE that fulfills this requirement could not also be counted as fulfilling the FTE consumers). The Psychiatrist's FTE and the physician extender's FTE combined would yield at least a 4 (.70 combined FTE per 100 requirements for the RNs for the team (i.e. no portion of an FTE may be counted twice).
- The ACT Team Psychiatrist would see each new admission to the ACT Team in a face-to-face appointment and would review each case with the physician extender on a monthly basis.
- The physician extender would be expected to participate in ACT team meetings at least once per week as would the supervising Psychiatrist be expected to participate in an ACT team meeting at least once per week.
- treatment, prevention of medical issues, rehabilitation, nutritional practices and works with the team to monitor each individual's overall physical health and (1-2 Fulltime Employee/s) RN/s who provide nursing services for all individuals, including health and psychiatric assessments, education on adherence to wellness, clinical status and response to treatment ပ
 - With 1-50 consumers, the requirement for the ACT team is to employ a Registered Nurse minimally .7-1 FTE (28 hrs./wk-40 hrs./wk.) providing ._:
- With 51-65 consumers, the requirement for the ACT team is to employ a Registered Nurse minimally .73 FTE-1.3 FTE (29.2 hrs./wk-52 hrs./wk). providing support to the team;
- With 66-75 consumers, the requirement for the ACT team is to employ a Registered Nurse(s) .93 FTE-1.5 FTE (37.2 hrs./wk-60 hrs./wk.) providing support to the team and; and ≔
- An addiction practitioner who holds a CAC-I (or other addiction certification equivalent or higher) and assesses the need for and provides and/or accesses With 76-100 consumers, the requirement for the ACT team is to employ a Registered Nurse (s) 1.3 FTE -2 FTE (52 hrs. /wk-80 hrs. /wk. providing support to the team. .<u>≥</u>

ö

- With 1-50 consumers, the requirement for the ACT team is to employ an addiction practitioner minimally .7-1 FTE (28 hrs./wk-40 hrs./wk.) providing substance use disorder treatment and supports for team consumers. support to the team; and
 - With 51-65 consumers, the requirement for the ACT team is to employ an addiction practitioner minimally .73 FTE-1.3 FTE (29.2 hrs./wk-52 hrs./wk.) providing support to the team; and :=**:**
 - With 66-75 consumers, the requirement for the ACT team is to employ an addiction practitioner. 93 FTE-1.5 FTE (37.2 hrs./wk-60 hrs./wk.) providing support to the team; and ≔
- With 76-100 consumers, the requirement for the ACT team is to employ an addiction practitioner 1.3 FTE -2 FTE (52 hrs. /wk-80 hrs. /wk. providing support to the team. .<u>≥</u>

Assertive Community Treatment

- The ACT team is required to respond to the crisis needs of ACT enrolled individuals, both directly and via collaboration with Mobile Crisis Response Service MCRS). ACT teams will receive a phone call from MCRS when a GCAL call has been received for ACT enrolled consumers in crisis. Upon receipt of the call, the ACT team must;
- i. Respond to the MCRS call within 15 minutes of receipt; and
- Engage in discussion w/ MCRS regarding clinical and/or crisis needs and location of individual; and
- Agree upon appropriate intervention/response which shall be provided within 1 hour of completion of call, either in the form of ACT team responding in person, MCRS team responding in person or another agreed upon in-person response.
- b. ACT teams are required to respond with face-to-face evaluation and/or intervention to at least 85% of all crisis calls coming through GCAL involving their respective ACT enrolled individuals over the course of fiscal year.
- The organization must have an Assertive Community Treatment Organizational Plan that addresses the following descriptions: ω.
- a. Particular rehabilitation, recovery and resource coordination models utilized, types of intervention practiced, and typical daily schedule for staff.
- Staffing pattern and how staff are deployed to assure that the required staff-to-individual ratios are maintained, including how unplanned staff absences, illnesses, and emergencies are accommodated.
 - Hours of operation, the staff assigned, and types of services provided to individuals, families, and/or guardians.
- How the plan for services is modified or adjusted to meet the needs specified in the Individualized Recovery Plan.
- Inter-team communication plan regarding individual support (e.g., e-mail, team staffings, staff safety plan such as check-in protocols etc.).
 - A physical health management plan.
- How the organization will integrate individuals into the community including assisting individuals in preparing for employment.
 - h. How the organization (team) will respond to crisis for individuals served.
- should document attempts to engage, identify, or build support networks at least 2 to 4 times per month. Informal supports are defined as persons who are not paid to support the individual (i.e., family, friends, neighbors, church members, etc.). Monthly maximum billing for informal support contacts without an individual support and skill training as necessary to assist the individual in his or her recovery. For individuals who have no identified informal supports, team members The ACT team is expected to work with informal support systems at least an average of 2 to 4 times a month with or without the individual present to provide being present shall not exceed 4 hours. <u>ග</u>
- For the individuals which the ACT team supports, the ACT team must be involved in all hospital admissions and hospital discharges. The agency will be reviewed for fidelity by the standard that the ACT team will be involved with 95% of all hospital admissions and hospital discharges. This is evidenced by documentation in
- health, addiction, and functional assessments may take up to 60 days. Enrolled individuals will be re-assessed at 6-month intervals from date of completion of the first individualized recovery plan. Because of the complexity of the mental illness and the need to build trust with the served individual, the comprehensive mental results from the information gathered and are used to establish immediate and longer-term service needs with each individual and to set goals and develop the The entire ACT team is responsible for completing the ACT Comprehensive Assessment for newly enrolled individuals. The ACT Comprehensive Assessment involved in assessment activities and ACT team documentation will demonstrate this participation. The ACT Comprehensive Assessment shall (at a minimum) comprehensive assessment. It is expected that when a person identifies and allows his/her natural supports to be partners in recovery that they will be fully Ξ.
- a. Psychiatric History, Mental Status/Diagnosis.
 - b. Physical Health.
- Substance Use assessment.
- d. Education and Employment.
- e. Social Development and Functioning.
- Family Structure and Relationships.

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Assertive Community Treatment 12. Treatment and recovery support to the individual is provided in accordance with a Recovery Plan. Recovery planning shall be in accordance with the following: a. The Individual Treatment Team (ITT) is responsible for providing much of the individual's treatment, rehabilitation, and support services and is charged with the development and continued adaptation of the person's recovery plan (along with that person as an active participant). The ITT is a group or combination of three to five ACT staff members who together have a range of clinical and rehabilitation skills and expertise. The ITT members are assigned by the time of the first recovery/resiliency planning meeting or thirty days after admission. The key members are the primary practitioner and at least one clinical or rehabilitation staff person who shares case coordination and service provision tasks for each individual. ITT members are assigned to take separate service roles with the individual as specified by the individual and the ITT in the IRP.	 b. The Recovery Plan Review is a thorough, written summary describing the individual's and the ITT's evaluation of the individual's progress/goal attainment, the effectiveness of the interventions, and satisfaction with services since the last person-centered IRP. c. The Recovery Planning Meeting is a regularly scheduled meeting conducted under the supervision of the team leader and the psychiatric prescriber. The purpose of these meetings is for the staff, as a team, and the individual and his/her family/natural supports, to thoroughly prepare for their work together. The group meets together to present and integrate the information collected through assessment in order to learn as much as possible about the individual's life, his/her experience with mental illness, and the type and effectiveness of the past treatment they have received. The presentations and discussions at these meetings make it possible for all staff to be familiar with each individual and his/her goals and aspirations and for each individual and his/her goals. 		 In order to maintain compliance with the DACTS fidelity model, each ACT team may enroll a maximum of 8 individual admissions per month. Allowing teams to meet and maintain the expectation of an active average daily census of at least 75 individuals. It is expected that 90% or more of the individuals have face to face contact with more than one staff member in a 2-week period. 	1. Services must be available by ACT Team staff skilled in crisis intervention 24 hours a day, 7 days a week with emergency response coverage, including	2. The team must be able to rapidly respond to early signs of relapse and decompensation and must have the capability of providing multiple contacts daily to	individuals in acute need. 3. An ACT staff member must provide this on-call coverage.		•	service by using the code above with the GT modifier. Telemedicine is not to be utilized as the primary means of delivery of psychiatric services for ACT consumers and should not exceed 50% of psychiatric contacts.	1. ACT teams are expected to submit all requisite information in order to establish eligibility for the initial authorization, and if an individual meets eligibility they receive a 12-month authorization for ACT services. During the first 12-months, consumers receive an automatic-authorization for the first 4 authorizations for an information that the ACT exercises ACT teams are required to submit information that the ACO exercises as a "required to submit information that the ACO exercises as a "required to submit information that the ACO exercises as a "required to submit information that the ACO exercises as a "required to submit information that the ACO exercises are a submit to submit the ACO exercises as a "required to submit the account to		the use of the term "reauthorization" is merely a data collection process and not a clinical review for eligibility every 90 days ACT teams are expected to submit all requisite information in order to establish continued eligibility for the concurrent review, this reauthorization review for medical necessity time frame is 180 days	and begins after the finite of authorization must be entered into the ASO system within three days of establishing eligibility for ACT services.
ve C							>					nts	
Asserti							Service Accessibility				Billing & Reporting	Requirements	

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Unity Treatment Will restrict a specific to some laining authorizations for service and all Bronch concurrent authorizations in a timely manner. All continuing skey actual distriction must be submitted in advance of the expirations for service and all Bronch concurrent authorization. All time specific between 2 or more team practitioners slicusating a served individual must be submitted in advanced in a practitioners slicusating as served individual must be reported as House 2 or this service can be included in future are setting. B. Served individuals inspecification that the service are be included in future are setting. B. Served individuals inspecific must be serviced and shall be accessible to the DBHDD monthly as requested: C. Served individuals inspecific must be serviced and shall be accessible to the DBHDD monthly as requested: C. Served individuals inspecific must be serviced and services are provided in an institution for heard 10 seesses (Mulc. e.g. state or private psychiatric hospitals, emangency room visits, crisis stabilization program interactions as exp. C. Served findividuals inspections with crisis support services are provided in an institution for malarity of services are provided in an institution for malarity of services. C. Served findividuals inspections with crisis support services (including acute psychiatric hospitals or this sealon program with greater than 16 beds.), jail, or prison system. ACT may not be provided in an institution for malarial pleases (Mulc. e.g. state or private psychiatric hospitals or crisis stabilization program with greater than the annioled ACT-recipient, then the encounter shall be submitted as a part of the ACT type or care defined in the forther provided in an institution for malarity please and provided in the general requirements bound in Pact. Section III: Documentation Requirements of this sealon in the forther sorther section of percentage and provided in the general requirements for the section of the sorther section of percentage and prov		Case 1	L:16-cv-030	088-ELR	Docum	nent 448-73	Filed 11/29/23	Page 190 of 627
3. ACT tends and time of a small forthis and the claim/e forthis as well claim/e forthis as well be as when as well claim/e forthis as well be as well as when as well claim/e forthis as well for this as well b. If it is in the claim/e forthis as well as when a swell claim/e forthis as well b. If it is in the claim/e forthis as well b. If it is in the claim/e forthis as well b. If it is in the claim/e forthis as well b. If it is in the claim/e forthis as well b. If it is in the claim/e forthis as well b. If it is in the claim/e forthis as well b. If it is in the claim/e forthis as well by the claim/e forthis audit p and the claim in the claim/e forthis and the claim/e forthis and the claim in the cl	Assertive Community Treatment 3. ACT teams are expected to submit all initial authorizations for service and all 6-month concurrent authorizations in a timely manner. All continuing stay reauthorization must be submitted in advance of the expiration of the current authorization.		 a. Served individual's employment status; b. Served individual's residential status (including homelessness); c. Served individual's involvement with criminal justice system/s; d. Served individual's interactions with crisis support services (including acute psychiatric hospitals, emergency room visits, crisis stabilization program interactions, etc.). 		When group services are provided via an ACT team to in the Orientation to Services section of Part I, Section Each ACT program shall provide monthly outcomes da	Provice as we All tim claim/for this		re i. ii. The AC1 audit pu section docume
tive C	tive C						ntation	
Assertive Documentation Requirements	Asser						Docume	

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Assisted Ou	Assisted Outpatient Treatment Program	Iram												
Transaction Code	Code Detail	Code	Mod 1	Mod 2	Mod 3	Mod 4	Rate	Code Detail	Code	Mod 1	Mod 2	Mod 3	Mod 4	Rate
TBD	TBD	TBD												
	Assisted Outpatient Treatment (AOT) is the practice of providing court-ordered community-based mental health treatment under a civil commitment to individuals living with serious mental illness if it is determined that they may be a danger to themselves or others.	AOT) is th determine	e practic ₃d that th	e of prov ey may t	iding col	urt-order ger to th	ed commur emselves o	nity-based mental health tre r others.	atment und	er a civil	commitr	ment to ir	ıdividuals	living
	AOT facilitates engagement in treatment services and supports that may allow an individual to live independently in the community of their choice while living with a mental health diagnosis or co-occurring substance use disorder. It also helps providers focus their attention to work diligently to keep the enrolled individual engaged effective treatment, and to support them in reaching their personal recovery goals.	reatment (curring su ort them in	services Ibstance reaching	and supp use diso y their pe	oorts tha rder. It a rsonal r	t may all ilso help ecovery	low an indiv s providers goals.	and supports that may allow an individual to live independently in the community of their choice while living with a use disorder. It also helps providers focus their attention to work diligently to keep the enrolled individual engaged in I their personal recovery goals.	in the comm k diligently t	nunity of o keep t	their cho he enroll	ice while ed indivic	living witl dual enga	h a ged in
Service	This Program is a time-limited, multi-faceted treatment model for adults who are court-ordered through a Probate Court petition to enroll in an Assisted Outpatient Treatment Program for required structure and support to achieve and sustain recovery from behavioral health conditions. These services enable individuals served to:	nulti-facete structure	ed treatmand supp	ent mod ort to ac	el for ad hieve an	ults who	are court-c n recovery 1	ordered through a Probate (from behavioral health conc	Sourt petitio ditions. The	n to enro se servio	ıll in an A es enabl	ssisted (Outpatient uals serve	ed to:
	 Maintain residence in their confindinty, Continue to work and go to school, Stay connected to friends and family life, Transition to voluntary treatment past court involvement. 	ineir corni go to schc nds and fa treatment	nunity, ool, imily life, : past cot	ut involv	ement.									
	All behavioral health services described in this manual are available to individuals in the AOT Program, subject to clinical necessity and the requirements of the particular service being considered. Intellectual and Developmental Disability services may also be available to individuals in the Program who have a co-occurring intellectual or developmental disability, subject to the eligibility requirements for those services.	scribed in ed. Intelle ability, suk	this mar ctual anc ject to th	iual are ¿ I Develop ie eligibil	available omental ity requii	to indivi Disabilit rements	iduals in the y services n for those se	AOT Program, subject to nay also be available to incervices.	clinical nece lividuals in t	ssity an	d the req am who	uirement have a c	s of the o-occurrir	Bi

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Assisted Or	Assisted Outnatient Treatment Program
	An individual can be enrolled in the Assisted Outpatient Treatment Program if: 1. A petition has been signed by a probate judge of the county of the individual's residence, AND
	2. AOT service is available in the county the individual resides: AND
	a. The person is 18 years or age or older; and b. The person is suffering from a mental health or co-occurring substance use disorder which has been clinically documented by a health care provider licensed
	to practice in Georgia; and c. There has been a clinical determination by a physician or psychologist that the person is unlikely to survive safely in the community without supervision; and d. The person has a history of lack of compliance with treatment for his or her mental health or co-occurring substance use disorder, in that at least one of the following is true:
Admission Criteria	i. The person's mental health or co-occurring substance use disorder has, at least twice within the previous 36 months, been a substantial factor in necessitating hospitalization or the receipt of services in a forensic or other mental health unit of a correctional facility, not including any period during which such person was hospitalized or incarcerated immediately preceding the petition: or
	ii. The person's mental health or co-occurring substance use disorder has resulted in one or more acts of serious and violent behavior toward himself or herself or others or threatens or attempts to cause serious physical injury to himself or herself or others within the preceding 48 months, not including any period in which such person was hospitalized or incarcerated immediately preceding the petition: and
	The
	g. Participation in the assisted outpatient treatment program would be the least restrictive placement necessary to ensure such person's recovery and stability; and
	h. In view of the person's treatment history and current behavior, such person is in need of assisted outpatient treatment in order to prevent a relapse or deterioration that would likely result in grave disability or serious harm to himself or herself or others; and i. It is likely that the person may benefit from assisted outpatient treatment.
	An individual may remain in the AOT Program as long as:
Continuing Stav	•
Criteria	
	4. There is a reasonable expectation that the individual can achieve their IRP goals in the necessary reauthorization timeframe.
	An individual may be discharged from the AOT Program if:
Uischarge Criteria	An adequate continuing care or discharge plan is established, and Linkages are in place, and
Service Exclusions	1. Individuals who are not under court-order from the probate court to be enrolled in the AOT Program are not eligible. 2. When higher intensity services are utilized, documentation must indicate efforts to minimize duplication of services and effectively transition individuals to appropriate services of lower intensity when appropriate.
	appropriate our rock of recent markets appropriate.

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Assisted Outpatient Treatment Program 1. Individuals who do not meet the eligibility requirements for each service for which admission is sought. 2. Individuals with the following conditions are excluded from admission unless there is clearly documented evidence of a psychiatric condition co-occurring with one of the following diagnoses: Developmental Disability, Autism, Neurocognitive Disorder, Substance Use Disorder.	 While a court order may have been issued for this program, the provider must assess, determine, and complete an order for the unique services and supports needed by the individual, in keeping with standards set forth in Part II of this manual. The program incorporates information from a court ordered evaluation, provider assessments and the individual's personal goals into the treatment planning process and resulting IRP. While this is a court-ordered program, all aspects of programmatic and service delivery are subject to the stipulations set forth in the Service Definition for each service delivered, as well as to all requirements in Part II of this manual. The program must operate at a site approved to bill DBHDD/Medicaid for services. However, limited individual or group activities may take place off-site in natural community settings as is appropriate to each individual's recovery plan. Program must have in place appropriate accreditation and licenses for all established service sites. The program provides individual treatment compliance and status reports as needed prior to and during court staffing/judicial review meetings. Any decrease in engagement levels should be reported to identified court as soon as possible for court review (incidents to be reported to the court include but are not limited to 	missed appointments, inappropriate behavior toward staff or other participants, damage to property, non-compliance with provider policies). 6. Provider will develop written agreements, partnerships, and memoranda of understanding (MOU) with key justice, mental health and substance use disorder treatment providers, recovery community advocates and support partners, consumer groups on an ongoing basis for the purpose of cooperative wrap around services and for developing sustainable activities. 7. In cases where an individual is in an inpatient facility, prior to discharge from the facility, an AOT team member shall engage with the individual and explain the AOT program expectations. The individual must have a written document with the outpatient appointment date and time and the AOT program expectations (Participant Handbook) upon discharge. 8. All individuals enrolled in the AOT program shall receive a Participant Handbook and Assisted Outpatient Treatment Enhancement Program Framework upon enrollment to the AOT program. 9. All participants and significant family members (caregivers) shall be given the opportunity and encouraged to complete the AOT Participant/Family Satisfaction Survey upon discharge from the AOT program. 10. At a minimum, the entire AOT Team shall meet to discuss and status all individuals enrolled in the AOT Program. Other service providers from the agency or community may be invited to supply relevant information on the status of any individual enrolled.	The AOT Team will maintain a maximum caseload of 25 participants to allow for frequent contact with the individual. The AOT team, working with the treating psychiatrist and other appropriate staff, monitors the individual's engagement in treatment and observes for behavior changes similar to previous behavior that preceded a psychiatric decompensation. Every AOT Team includes the following staff: 1. Team Lead Clinician (1 FTE) Duties shall include, but not limited to: a. Assisting the individual in identifying and resolving personal, social, vocational, intrapersonal, and interpersonal concerns. b. Providing services (or be responsible for the oversight of service provision) to address goals/issues such as promoting recovery, and the restoration, development, enhancement, or maintenance of: i. Illness and medications eff-management knowledge and skills (e.g., symptom management, behavioral management, relapse prevention skills, knowledge of medications and side effects, and motivational/skill development in taking medication as prescribed); ii. Problem solving and cognitive skills; iii. Healthy coping mechanisms; iv. Adaptive behaviors and skills;
Assisted Colinical Exclusions		Required Components	Staffing Requirements

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Assisted Outpatient Treatment Program

- Interpersonal skills; and
- Knowledge regarding mental illness, substance related disorders and other relevant topics that assist in meeting the individual's or the support
- Behavioral Therapy, Behavioral Modification, Behavioral Management, Rational Behavioral Therapy, Dialectical Behavioral Therapy, and others as Use best/evidence-based practice modalities which may include (as clinically appropriate): Motivational Interviewing/Enhancement, Cognitive appropriate to the individual and clinical issues to be addressed.
- Conducting a monthly IRP review and, with input from the Team, to determine progress made, barriers to success, and whether the individual continues to meet criteria for court-ordered treatment criteria. Findings should be submitted through the 30-Day Review report.
 - Submit reports and updates to the court, as requested, or presented at status hearings conducted by the probate judge.
 - Monitoring each AOT enrolled individual, and determine appropriate actions, when warranted.
 - Completing identified documentation in a timely manner.
- Case Manager (1 FTE) The case manager monitors the individual's stability and ensures that care is provided in the least restrictive setting consistent with the ndividual's needs. Duties shall include, but not limited to: ςi
- community integration and maintain housing stability. Through engagement, the case manager partners with the individual to identify and prioritize housing, Engagement & Needs Identification: The case manager engages the individual in a recovery-based partnership that promotes personal responsibility and provides support, hope, and encouragement. The case manager assists the individual with developing a community-based support network to facilitate service and resource needs to be included in the IRP.
- Care coordination requires information sharing among the individual, his/her Tier 1 or Tier 2 provider, specialty provider(s), residential provider, primary care Ensure that the individual receives a full range of integrated services necessary to support a life in recovery that includes health, home, purpose, and Sare Coordination: The case manager coordinates care activities and assists the individual as he/she moves between and among services and supports. physician, and other identified supports in order to:

9

- Ensure that the individual has an adequate and current crisis plan;
 - Reduce barriers to accessing services and resources; ≔
- Minimize disruption, fragmentation, and gaps in service; and .≥
- Ensure all parties work collaboratively for the common benefit of the individual.
- social supports, family/natural supports, entitlements (SSI/SSDI, Food Stamps, VA), income, transportation, etc. Referral and linkage activities may include Referral & Linkage: The case manager assists the individual with referral and linkage to services and resources identified on the IRP including housing, assisting the individual to: ပ
- Locate available resources;
- Make and keep appointments;
- Complete the application process; and ≔
- Make transportation arrangements when needed.
- Monitoring and Follow-Up: The case manager visits the individual in the community to jointly review progress made toward achievement of IRP goals and to seek input regarding his/her level of satisfaction with treatment and any recommendations for change. The case manager monitors and follows-up with the ndividual in order to: ö
- Determine if services are provided in accordance with the IRP;
- Determine if services are adequately and effectively addressing the individual's needs;
- Determine the need for additional or alternative services related to the individual's changing needs or circumstances; and :≓ :≓ .≥
 - Notify the treatment team when monitoring indicates the need for IRP reassessment and update.

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This states streagont contributions of the contribution of the contributions of the contribution of the contributions of the contribution of the contributions of the contribution of the contributions of the contributions of the contribution of the	Case 1:16-cv-03088-ELR	Document 448-73	Filed 11/29/23	Page 196 of 62
https://https:	//gets.sharepoint.com/x/r/sites/DBHDDExtranet/JS977C72F0%7D&file=AOT%20Data%20Collection%977C72F0%7D&file=AOT%20Data%20Collection%AOT Participant Information (demographic data): S12 Months Pre-AOT (historical data): All efforts to gmedical records, other ERF records, family, etc. Ac During AOT (ongoing status and significant events) 12 Months Post-AOT (continued monitoring of part 30-Day Review (ongoing reviews): This review musto the partnered probate court upon request of the Determination of Renewal (request for continued edischarge criteria but if renewal of the current court expiration date and submitted to the court no less to Request for Immediate Court Action/Conference: Sincident occurs that warrants court intervention.		le Mod Mod Mod Rate Code Detail Code Mod	nation atric y also spital

Requirements

Additional Medicaid

Reporting

Billing &

Requirements

Assisted Outpatient Treatment Program

Community	Community Based Inpatient Psychiatric	ric												
Transaction Code	Code Detail	Code N	Mod N	N pol	Mod Mod Mod 2 3 4		Rate	Code Detail	Code	Mod 1	Mod 2	Mod N	Code Mod Mod Mod Mod Rate	(I)
Psychiatric Health Facility Service, Per Diem		H2013				ш.с	Per negotiation							
Unit Value	1 day							Utilization Criteria	LOCUS Level 6	Level (
Service Definition	A short-term stay in a licensed and accredited community-based hospital for the stabilization of a psychiatric crisis. The service is of short duration and provides treatment for individuals experiencing an acute psychiatric crisis episode due to a new or recurring mental illness, non-compliance with medications, or a combination of these causes. The intent of this service is to provide short-term recovery-oriented treatment and support that increases the functioning of persons with psychiatric disabilities. The service should include tailored interventions based upon the individual's unique needs as identified in their individualized recovery plan, but may also include routinely available interventions provided by a contractor's inpatient program milieu, as clinically indicated. Upon stabilization of the psychiatric crisis, the individual is connected to the appropriate level of care and transitioned back into the community. Specific desired outcomes of this service are: 1) Successful hospital to community transition, 2) Effective collaboration with community service providers and field offices, 3) Effective discharge planning, 4) Linkage and referral to community services, 5) Reduction in hospital readmissions.	d accredited sing an acut service is t slude tailore ntions provii opriate leve ve collabora	I commu e psychi o provide d interve ded by a ded by a do care lition with	nity-bas atric cris s short-t- intions b contrac and tra commu	ed hospii sis episoc erm reco- ased upc tor's inpa tor's inpa tor's inpa nsitioned	tal for the due to the due to very-ori on the ir the ir the ir the due to the	ie stabilizatic o a new or re ented treatm idividual's ur ogram milieu tto the comm iders and fie	on of a psychiatric crisis. The securing mental illness, non-coent and support that increase inque needs as identified in th, as clinically indicated. Upon unity. Specific desired outcor id offices, 3) Effective dischar	service is compliance is the fur eir indiving stabilizes nes of the ge planr	s of sho se with ractioning dualized trion of ractions in servi	ort durat medicat g of per d recove the psy ce are: Linkage	ion and ions, or sons wit sons wit sons wit six plan, chiatric chiatric (1) Succes and references	provides a combine h psychiat but may rrisis, the sssful hos erral to	rric also pital

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Community	Community Based Inpatient Psychiatric
Admission Criteria	For individuals defined as the target population for the DBHDD contract, the Inpatient Psychiatric hospital will accept referrals for admission solely from DBHDD and its designated ASO agents: Behavioral Health Link (BHL) or Beacon Health Options (BHO). This service will utilize the DBHDD-required board monitoring system, providing regularly updated information to ensure appropriate utilization of inpatient beds. Admissions are for an: 1. Individual with serious mental illness who presents a substantial risk or harm to himself/herself or others, as manifested by recent overt acts or recent expressed threats of major suicidal, homicidal or high-risk behaviors as a result of the mental illness which present a probability of physical injury to himself/herself or others; OR 2. Individual with serious mental illness is so unable to care for his/her own physical health and safety as to create an imminently life-endangering crisis.
Continuing Stay Criteria	 Individual meets the following: a. Continues to meet admission criteria; and has been assessed to be at risk of major suicidal, homicidal or high-risk behaviors; and b. Is assessed as requiring continued hospitalization beyond the initial authorization, 2. When the individual has received and expended two (2) concurrent authorizations or by the ninth day of admission, the individual must be placed on the state hospital transfer list.
Discharge Criteria	At which point the risk and crisis are determined to no longer exist, the individual must be transferred to a lower level of care/discharged with an adequate continuing care plan. Absence of the risk and crisis must be accompanied by one or more of the following: 1. Individual no longer meets admission and continued stay criteria; or 2. Individual requests discharge and individual is not imminently dangerous to self or others; or 3. Transfer to another service/level of care is warranted by change in the individual's condition; or 4. Individual requires services not available in this level of care.
Service Exclusions	This service may not be provided simultaneously with any other service in the DBHDD behavioral health service array excepting short-term access to services that provide continuity of care or support in planning for discharge from this service. Any individual with a substance use disorder or a substance-induced psychiatric disorder as their primary diagnosis should not be admitted for the purpose of detoxification.
Clinical Exclusions	Individuals with any of the following conditions are excluded from admission unless there is clearly documented evidence of a co-occurring acute psychiatric diagnosis: Autism, Developmental Disabilities, Neurocognitive Disorder, or Traumatic Brain Injury.

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Community Based Inpatient Psychiatric

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Community	Ba	Community Based Inpatient Psychiatric
	1.	. This service requires authorization via the ASO via GCAL. Providers will select an individual from the State Contract Bed (SCB) Board. Once they accept them,
		they will assign the individual to a bed on the inventory status board (via bhlweb). Once an individual is assigned to the inventory status board a tracking number
		will be generated and the information will be sent from the Georgia Collaborative ASO crisis access team to the Georgia Collaborative ASO care management
		team for registration/authorization to take place. Once an authorization number is assigned, that number will appear on the beds inventory status board (on
		bhlweb) and an email will be generated and sent to the designated UM of the SCB facility containing the authorization number.
Billing &	2	Span billing may occur for this service, meaning the start and end date are not the same on a given service claim line). The span dates may cross months (start
Reporting		date and end date on a given service line may begin in one month and end in the next).
Requirements	დ.	If the initial authorization period expires and there is documentation that the individual meets medically necessary continuing stay criteria, the individual must be
		placed on the Transfer-to-a-State-Hospital referral list via the Beacon bed board process as a requirement for reimbursement of any additional authorized days.
		In the absence of this documentation, service may continue at the expense of the facility.
	4	Providers must submit a discharge summary into the Provider Connect/batch system within 48 hours of discharge.
	5.	Submission of supporting documentation is required as part of all billing submissions (examples of supporting documentation include, but are not limited
		to: Nursing notes. MAR. physician notes. treatment plan. etc.).

:	1													
Community	Community Support Team													
Transaction	Code Detail	Code	Mod	роМ	Mod Mod Mod Rate	Mod		Code Detail	Code	Mod	Mod	Mod Mod Mod Mod	Mod	Rate
Code			_	7	ر س	4				-	2	က	4	
	Practitioner Level 3, In-Clinic	H0039	N	EN	90		\$30.01	\$30.01 Practitioner Level 3, Out-of-Clinic	H0039	N	U3	U2		\$36.68
	Practitioner Level 4, In-Clinic	H0039	NL	U4	90		\$20.30	\$20.30 Practitioner Level 4, Out-of-Clinic	H0039	N	U4	U2		\$24.36
	Practitioner Level 5, In-Clinic	H0039	N	OS	90		\$15.13	Practitioner Level 5, Out-of-Clinic	H0039	N	U5	U2		\$18.15
	Practitioner Level 3, Via													
	interactive audio and video	H0039	Z	GT	U3		30.01							
Community	telecommunication systems													
Support Team	Practitioner Level 4, Via													
	interactive audio and video	H0039	N	GT	V		20.30							
	telecommunication systems													
	Practitioner Level 5, Via													
	interactive audio and video	H0039	Z	GT	U5		15.13							
	telecommunication systems													
Unit Value	15 minutes							Utilization Criteria	TBD					

Community Support Team (CST) is an intensive behavioral health service for individuals with severe mental illness living in rural areas of the State who are discharged

from a state or private psychiatric hospital or Psychiatric Residential Treatment Facility (PRTF) after multiple or extended stays or from multiple discharges from crisis stabilization unit(s), or discharged from correctional facilities or other institutional settings, or those leaving institutions who are reluctant to engage in treatment. This

service is provided in rural areas, where there is less demand for service, and/or in areas with professional workforce shortages. CST utilizes a mental health team led

tenure/independent functioning; increasing time working or with social contacts; and increasing personal satisfaction and autonomy. Through active assistance and by a licensed clinician to support individuals in decreasing hospitalizations, incarcerations, emergency room visits, and crisis episodes and increasing community

based on identified, individualized needs, the individual will be engaged in the recovery process.

Service Definition CST is a restorative/recovery focused intervention to assist individuals with:

Gaining access to necessary services;

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Community 5	Community Support Team
	 3. Individual with one (1) or more of the following as indicators of continuous high-service needs (i.e., greater than 8 hours of service per month): a. High use of acute psychiatric hospitals or crisis/emergency services including mobile, in-clinic or crisis residential (e.g., 3 or more admission per year) or extended hospital or PRTF stay (60 days within the past year) or psychiatric emergency services; b. Persistent, recurrent, severe, or major symptoms (e.g., affective, psychotic, suicidal); c. Coexisting substance use disorder of significant duration (e.g., greater than 6 months) or co-diagnosis of substance abuse (ASAM Levels I, II.1, II.5, III.3,
	 III.5); d. High risk or a history of criminal justice involvement (e.g., arrest and incarceration); e. Residing in an inpatient bed or in a supervised community residence, but clinically assessed to be able to live in a more independent living situation if intensive services are provided, or requiring a residential or institutional placement if more intensive services are not available; f. Inability to participate in traditional clinic-based services:
	AND 4. A lower level of service/support has been tried or considered and found inappropriate at this time.
Continuing Stay	 Individual continues to have a documented need for a CST intervention at least four (4) times monthly such as to maintain newly established housing stability (within past 6 months), improved community functioning and/or self-care and illness self-management skills (such as attending scheduled appointments and taking medications as prescribed without significant prompting, using crisis plan as needed, accessing community resources as needed most of the time). AND
ם ב ב	 Individual continues to meet the admission criteria above; or Individual has continued difficulty participating in traditional clinic-based services or a community setting at a less intensive level of service/supports; or Individual has continued difficulty participating in traditional clinic-based services or a community setting at a less intensive level of service/supports; or Individual is in substandard housing, homeless, or at imminent risk of becoming homeless due to functional impairments associated with behavioral health issues.
Discharge	 There has been a planned reduction of units of service delivered and related evidence of the individual sustaining functioning through the reduction plan; and An adequate continuing care plan has been established; and one (1) or more of the following: Individual no longer meets admission criteria; or Goals of the Individualized Recovery Plan have been substantially met; or
Circlia	 c. Individual requests discharge and is not in imminent danger of harm to self or others; or d. Transfer to another service/level of care is warranted by a change in individual's condition; or e. Individual requires services not available in this level of care.
	 It is expected that the CST attempt to engage the individual in other rehabilitation and recovery-oriented services such as Housing Supports, Residential Services, group-oriented Peer Supports, group-oriented Psychosocial Rehabilitation, Supported Employment, etc.; however, ACT, Family Counseling, Family Training, Nursing Assessment, ICM and CM are Service Exclusions. Individuals may receive CST and one of these services for a limited period of time to facilitate a smooth transition.
Service Exclusions	2. SA Intensive Outpatient Program (SAIOP) is generally excluded; however, if a substance use disorder is identified and documented as a clinical need, and the individual's understanding the individual in the individual in accessing the SAIOP service, but must ensure clinical coordination in order to avoid duplication of specific service interventions.
	3. Specialized evidence-based practices are not service exclusions (excluded) when the needs of an individual exceed that which can be provided by the CST team (e.g. specialized treatment for PTSD, eating disorders, personality disorders, and/or other specific clinical specialized treatment needs). In this case, the Individual's Recovery Plan (IRP) must reflect the necessity for participation in such services along with medical record documentation of the unique need and resulting collaboration between service providers to ensure coordination towards goals and to prevent any duplication of services/effort.
Olinical Exclusions	1. Individuals with the following conditions are excluded from admission unless there is clearly documented evidence of psychiatric condition/substance use disorder co-occurring with one of the following diagnoses: Intellectual/Developmental Disabilities, Autism, Neurocognitive Disorder, Substance-Related Disorder.

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Community 5	Community Support Team		
	2. Individuals may be excluded if there is evidence that they are impairment due to an I/DD diagnosis.	Individuals may be excluded if there is evidence that they are unable to participate in the development of their Individual Recovery Plan as a result of significant impairment due to an I/DD diagnosis.	
	um of once a v	week and time dedicated to discussion of support and service to individuals must be documented in the	_
		be discussed, even if briefly, at least one time weekly. CST staff members are expected to attend Treatment	Ca
	erventions must be individually tailor	ed to the needs, goals, preferences and assets of the individual with the goals of maximizing independence	se
	and recovery as defined by the individual.		1:1
	3. At least 60% of all service units must involve face-to-face cor	At least 60% of all service units must involve face-to-face contact with individuals. The majority (51% or greater) of face-to-face service units must be provided	L6-0
	preference and clinical appropriateness).	ouside of program offices in rocations that are commontable and convenient for individuals (including the mandament) based on mandament and preference and clinical appropriateness).	cv-(
Required	4.	A minimum of four (4) face-to-face visits must be delivered monthly by the CST. Additional contacts above the monthly minimum may be either face-to-face or	030
Components	Ľ	telephone collateral contact depending on the individual's support needs and keeping to the expected 60% of units being face-to-face.	88
		and make contact with an individual and has demonstrated diligent search, after 45 days of unsuccessful attempts the individual may be discharged due to drop	-ELI
	out.		R
	6. While the minimum percentage of contacts is stated above, in	above, individual clinical need is always to be met and may require a level of service higher than the	
		established minimum criteria for contact. UST teams will provide the clinically required level of service in order to achieve and maintain desired outcomes.	Do
	Individuals will be provided assistance by the CST team with completion of the bounding peed and choice survey bythe (194).	Individuals will be provided assistance by the UST team with gaining skills and resources necessary to obtain nousing or the Individual's choice, including	cui
	be minimally updated at each reauthorization.	competion of the flousing freed and choice survey <u>migos, flouridangos, united with the development of a flousing goal, which will</u> be minimally updated at each reauthorization.	me
	1. A CST shall have a minimum of 3.5 team members which m	which must include:	nt 4
	a. (1 FTE) A fulltime dedicated Team Leader ("Dedicated	a. (1 FTE) A fulltime dedicated Team Leader ("Dedicated" means that the team leader works with only one team at least 32 hours and up to 40 hours/week)	148
) and provides clinical and administrative supervision of the team. This individual must have at least four (4)	3-7
	years of documented experience working with adults w	years or documented experience working with adults with a SPMI and is preferably certified/credentialed as a substance use disorder counselor (CAC-I portification or higher). The Team Leader is responsible for working with the team to monitor each individual's physical health, clinical status and response to	3
	equivalent of higher). The Teaust is responsible treatment.	טן שטוחווט שונו נוד נפמוו נס וווסוונטן פמטו וווטועעממן א מונאסוטמן וופמונון, טווווטמן אנמנטא מונט ופאסוואס נט	F
	b. (1 FTE) A fulltime or two half-time (.5 FTE) Certified Pe	(1 FTE) A fulltime or two half-time (.5 FTE) Certified Peer Specialist (s) who is/are fully integrated into the team and promotes individual self-determination	ile
	and decision-making and provides essential expertise	and decision-making and provides essential expertise and consultation to the entire team to promote a culture in which each individual's point of view and	d 1
Staffing	•	preferences are recognized, understood, respected and integrated into treatment, rehabilitation, medical, and community self-help activities.	1/2
Requirements	ပ် —	(.3 FTE) A nain-time registered nurse (KN). This person will provide nursing care, neatin evaluation/reevaluation, and medication administration and will make referrals as medically necessary to psychiatric and other medical services. Begistered nurses may be clinic based with provision of community, based/	29/
	in the home services as needed. Nursing face-to-face t	in the home services as needed. Nursing face-to-face time with each individual served by the team is determined based on the IRP, physician assessment.	23
	and is delivered at a frequency that is clinically and/or i	and/or medically indicated.	
	A fulltime Paraprofessional level team	member, minimally bachelor's level, preferably with a SUD counselor certification (CAC-I equivalent or	Pa
	higher).	higher). The CST maintains a small individual to staff ratio with a minimum of 10 individuals coursed not full time staff mamber (40:4) and a maximum of 20 individuals	ge
	served per staff member (20:1), yielding a 3-person	with a minimum of 10 manuages served before the family of 10 manual and a maximum of 20 manuages team's minimum capacity of 30 and a team maximum capacity of 60. The Individual-to-staff ratio range should	202
	consider evening and weekend hours, needs of the target population, and geographical areas to be served	ulation, and geographical areas to be served.	2 0
Clinical Operations	CST must incorporate assertive engagement techniques to ic intensive services. CST must demonstrate the implementation.	CST must incorporate assertive engagement techniques to identify, locate, engage, and retain the most difficult to engage individuals who cycle in and out of intensive services. CST must demonstrate the implementation of well thought out engagement strategies to minimize discharges due to drop out including the use	f 62
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Community Support Team

of street and shelter outreach approaches, legal mechanisms such as outpatient commitment (when clinically indicated), and collaboration with family, friends, parole and/or probation officers.

- needs, abilities, resources, and preferences. CST Team Lead may complete a comprehensive behavioral health assessment on new individuals as well as ongoing assessments to ensure meeting the individual's changing needs or circumstances. When a comprehensive behavioral health assessment is conducted by the CST CST is expected to gather assessment information from internal or external provider sources on existing individuals in order to identify the individual's strengths, Feam Lead, it may be billed as CST (see Billing & Reporting Requirements below). c,
- making sure individuals are connected to resources to meet their needs in alignment with their preferences. The team is responsible for ensuring the individual has access to services and resources such as housing, pharmacy, benefits, a support network, etc. when being discharged from a psychiatric hospital; released from meetings between stakeholders. The team is expected to coordinate care through a demonstrable plan for timely follow up on referrals to and from their service, connection or reconnection to the individual and participate in discharge planning meetings while the individual is in a state operated hospital, crisis stabilization ial; or experiencing an episode of homelessness. CST providers who are a Tier 1 or Tier 2+ Provider may use Community Transition Planning to establish a CST is expected to actively and assertively participate in transitional planning via in person or, when in person participation is impractical, via teleconference unit, jail/prison, or other community psychiatric hospital. რ.
 - reatment/support. It is expected that the IRP be individualized and recovery-oriented after the team becomes engaged with the individual and comes to know the Because CST-eligible individuals may be difficult to engage, the initial treatment/recovery plan for an individual may be more generic at the onset of ndividual. The allowance for "generic" content of the IRP shall not extend beyond 90 days. 4
- Because of the complexity of the target population, it is expected that the individual served will receive ongoing physician assessment and treatment well as other recovery-supporting services. These services may be provided by Tier 1 or Tier 2 Provider agency or by an external agency. There shall be documentation during each Authorization Period to demonstrate the team's efforts at consulting and collaborating with the physician and other recovery-supporting services. 5
 - CST will assist all eligible individuals with the application process to obtain entitlement benefits including SSI/SSDI, Food Stamps, VA, Medicaid, etc. including making appointments, completing applications and related paperwork. 9
 - Because many individuals served may have a mental illness and co-occurring substance use disorder, the CST team may not discontinue services to any individual based solely upon a relapse in his/her substance use disorder recovery.
- school), especially if staff drive a vehicle that is clearly marked as a state or agency vehicle, or if staff must identify themselves and their purpose to gain access to CST must be designed to deliver services in various environments, such as homes, schools, homeless shelters, and street locations. The provider should keep in the individual in a way that may potentially embarrass the individual or breech the individual's privacy/confidentiality. Staff should be sensitive to and respectful of individuals' privacy/confidentiality rights and preferences in this regard to the greatest extent possible (e.g., if staff must meet with an individual during their work mind that individuals may prefer to meet staff at community locations other than their homes or other conspicuous locations (e.g. their place of employment or nours, mutually agree upon a meeting place nearby that is the least conspicuous from the individual's point of view). ω.
 - The CST Crisis Plan must include a clear comprehensive approach for provision of 24/7 crisis response and emergency management of crisis situations that may occur after regular business hours, on weekends, and on holidays. <u>ග</u>
 - The Crisis Plan should demonstrate a supportive linkage and connection between the organization and CST.
- A CST will ensure coordination with the Tier 1 or Tier 2 services provider or other clinical home service provider in all aspects of the IRP.
- The CST agency must have established procedures that support the individual in preventing admission into psychiatric hospitalization/crisis stabilization. There The CST is required to provide follow-up for all CST-enrolled individuals for whom notification is received of a GCAL interaction/referral. 6.
- Using the information collected through assessments, the CST staff work in partnership with the individual's Tier 1 or Tier 2 provider, specialty provider, residential provider, primary care physician, and other identified supports to develop a Wellness Recovery Action Plan (WRAP) that meets the medical, behavioral, wellness, shall be evidence that these procedures are utilized in the support of the individual when a crisis situation occurs. social, educational, vocational, co-occurring, housing, financial, and other service needs of the eligible individual. Ξ.
- ndividual in their recovery. For individuals who have no identified informal supports, team members should document attempts to engage, identify, or build support The CST is expected to work with informal support systems (with or without the individual present) to provide support and skill training as necessary to assist the 12.

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Community Support Team

When Telemedicine technology is utilized for the provision of this service in accordance with the allowance in the Service Accessibility section of this definition, the code cited in the Code Detail above with the appropriate GT modifier shall be utilized in documentation and claims submission.

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	16. Pharmacy & Lab; 17. Psychological Testing 18. Community Transition Planning	
	* In addition to the billable DBHDD services named above, the DBHDD provides ancillary funding through CSC for FEP provider contracts for education and employment support interventions/activities, which are integral to the CSC for FEP model; and for other non-billable activities as described in the paragraph below.	Case 1
	In delivering the services outlined above, individualized interventions of particular importance to the CSC for FEP model include the following: 14.1. Psychoeducation on first episode psychosis, treatment options, and recovery to participants and their families; 12.2. Crisis planning, support, and intervention; 14.4. Instrumental/skill-building support to participants and their families; 14.4. Instrumental/skill-building support to participants and their families; 14.5. Service and resource coordination, including linkage to medical care; 14.6. Psychotherapy and skills training; 14.7. Family counseling, education, support, and skills training; 14.8. Substance use disorder counseling and interventions; 14.9. Peer support; and 20.10. Support for educational and employment endeavors.	::16-cv-03088-ELR Docu
	As an adjunct to direct service provision, CSC for FEP teams offer outreach and education activities/events within the community at large in order to identify individuals experiencing a first episode of psychosis, as well as to educate the community about behavioral health conditions, the CSC for FEP program, recovery principles and practice, and accessing the public behavioral health system. Outreach and education efforts are intended to establish a seamless community system of care for youth and young adults with first episode psychosis, and promote the sustainability of the program. The DBHDD provides funding to offset the costs for providers' time spent in these and other non-billable activities such as travel, meetings, trainings and conference attendance, community partner collaboration, and other related activities.	ment 448-73
	It is anticipated that individuals participating in CSC for FEP will experience a reduction in psychiatric symptoms or the debilitating effects of these symptoms; will show improved educational, occupational, and social functioning; and will require less frequent hospitalization and use of crisis services over time. Most participants remain with CSC for FEP teams for an average of two years; however, all decisions regarding discharge of participants from CSC for FEP programs should be based on clinical considerations.	Filed 11
Admission	 The target population for Coordinated Specialty Care for First Episode Psychosis is youth and young adults aged 16 – 30 with non-organic psychotic disorders. (e.g. schizophrenia, schizophreniform disorder, schizoaffective disorder, delusional disorder) or mood disorders with psychotic symptoms (e.g. bipolar disorder with psychotic symptoms) who have had symptoms of psychosis for no longer than 24 months. The target population is not to be limited to insurance coverage or lack thereof: individuals who have any kind of third-party insurance, or no insurance, must be served by the provider. 	/29/23 P
Criteria	 Youth and young adults who fall outside the target age range of 16 – 30, or who have had psychotic symptoms longer than 24 months, may be considered for enrollment in CSC for FEP services on a case-by-case basis, with prior approval from DBHDD. An individual does not need to have a diagnosis of a psychotic disorder to be evaluated for enrollment in CSC for FEP services. It is anticipated that for many youth and young adults referred to CSC for FEP teams, they will have had no previous mental health treatment and thus will not have received a diagnosis prior to their evaluation with the CSC for FEP team. 	age 206 of 6
Continuing Stay Criteria	Individual demonstrates documented progress relative to goals identified in the Individualized Recovery Plan (IRP), but goals have not yet been achieved, and/or new service needs have been identified.	627

Coordinated Specialty Care for First Episode Psychosis Program (CSC for FEP) (Effective Date January 1, 2023)

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Coordinate	Coordinated Specialty Care for First Episode Psychosis Program (CSC for FEP) (Effective Date January 1, 2023)	
Discharge Criteria	An adequate continuing care plan has been established; and one or more of the following: 4.1. Goals of the IRP have been substantially met; 5.2. Individual/family requests discharge and individual is not in imminent danger of harm to self or others; or	
	6-3. Transfer to another service is warranted by change in individual's condition and/or needs.	Ca
	 U. CSC for FEP is a comprehensive team intervention and most services are excluded, with the exceptions or: d-a. Residential or Housing Supports (the CSC for FEP provider shall be in close coordination with the Residential/Housing Support provider such that there is no diminisation of services supports/efforts): 	se 1:1
	e.b. Substance Abuse Intensive Outpatient Program: If a substance use disorder is identified and documented as a clinical need unable to be met by the CSC for EEP team, and the individual's current treatment programs indicates that provision of CSC for EEP services alone without an organized SLID program model is	16-c\
	not likely to result in the individual's ability to maintain sobriety, CSC for FEP teams may assist the individual in accessing this service, but must ensure clinical	/-030
	authorization to include group services to be utilized by the SAIOP program;	088-
	#.c The following are <u>not</u> service exclusions: ##: Individual Counseling and Group/Family Counseling/Training provided outside of the CSC for FFP program when the needs of an individual exceed	ELF
	that which can be provided by the CSC for FEP team. For example, the individual may participate in SA group treatment provided by a Tier 2,	₹
		D
0	++1 Specialized evidence-based practices delivered outside the CSC for FEP program utilizing a treatment modality (e.g. individual counseling, croup Counseling, etc.) that would otherwise be provided by a CSC for FEP team member <i>when</i> the needs of an individual exceed that which can be	ocu
Exclusions	provided by the CSC for FEP team (e.g. specialized treatment for PTSD, eating disorders, personality disorders, and/or other specific clinical specialized treatment needs). In this case, the individual's treatment plan must reflect the necessity for participation in such services along with	mer
		nt 44
	prevent any duplication of services/effort.	18-
		73
	Case Management/Intensive Case Management.	
		File
	c. AD Support Services	ed :
		11/2
		29/
	g. Physician Assessment	23
	. Individual Counseling Peer Support	F
	evere and profound intellectual/developmental disability are excluded because the severity of cognitive impairment precludes participation in	Page
	arate intellectual/developmental disability are excluded unless there is an identified mental illness that is the foremost consideration for	20
Exclusions	this psychiatric intervention, and the individual is able to benefit from the cognitive behavioral-based program components. Z.3 Individuals with medical conditions suspected to be causing the psychotic symptoms are excluded. [Examples: Neurological conditions including traumatic brain)7 o
	injury; brain tumor; endocrine, metabolic, or autoimmune disorders with central nervous system involvement.]	f 62
	8.4. Individuals whose psychotic symptoms are suspected to be caused by drug or alcohol intoxication or withdrawal are excluded.	7

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48-5. The CSC for FEP team must maintain a small participant-to-clinician ratio, with an expected census of 30 participants at a point-in-time based on a team FTE of approximately 5.0. 49-6. The CSC for FEP team is expected to retain a high percentage of enrolled individuals in services with few dropouts. In the event that the CSC for FEP program documents multiple attempts to locate and make contact with an individual and has demonstrated diligent search, after 90 days of unsuccessful attempts the individual may be discharged due to drop out. 20-7. The CSC for FEP team meeting. All CSC for FEP team meetings is to review the clinical status of all individuals in the CSC for FEP program and the outcome of the most recent staff contacts, individuals' progress toward their goals, barriers to progress toward goals, and strategies for eliminating these	14-15 The CSC for FEP team must respond to phone calls from participants and family members 24-hours/365-days, and either directly provide or refer individuals/families to any appropriate crisis services. 22-9. The CSC for FEP team should maintain a strong recovery orientation and commitment to hiring individuals with lived experience of mental illness. 23-10.CSC for FEP providers must have established procedures/protocols for handling emergency and crisis situations that describe methods that shall be taken by the team in supporting and responding to CSC for FEP-enrolled individuals who require emergency psychiatric admission/hospitalization and/or crisis stabilization. 24-11.CSC for FEP providers must have established procedures/protocols for handling emergency psychiatric admission/hospitalization and/or crisis stabilization. 24-11.CSC for FEP providers must have established procedures/protocols for FEP employed providers must have a Coordinated Specialty Care for First Episode Psychosis organizational plan that addresses the following: a. Staffing pattern and how staff are deployed, including how unplanned staff absences, illnesses, and emergencies are accommodated; b. Hours of operation and typical daily schedule for staff; c. Inter-team communication (e.g., e-mail, team staffing, staff safety plan such as check-in protocols, etc.); d. How the team will respond to crises for individuals served (e.g., on-call rotation schedule and protocols, etc.); e. For the individuals whom the CSC for FEP team supports, the confirmed the addresses and the need to build trust with the referred individuals, whenever possible, and this involvement should be documented in the clinical record. f. Because of the often complex mental health, addiction, and functional assessments may take up to 60 days. The assessments and Family Structure and Status/Dagnosis, Physical Health, Substance Use, Educa	25-12. In addition to services provided to individuals enrolled in the program, the CSC for FEP team must provide outreach and education activities/events to the community at large regarding behavioral health conditions, first episode psychosis and the CSC for FEP program, recovery and wellness principles and practice, and information on how to access the public behavioral health system. 26-13. CSC for FEP providers must have policies and procedures governing the provision of community outreach and education services, including methods for protecting the safety of staff who engage in these activities. 1. Coordinated Specialty Care team members must include: 26-13. CSC for FEP providers must have engage in these activities. 26-13. CSC for FEP providers and well-staff who engage in these activities. 26-13. CSC for FEP providers and methods for providing the care and methods for protecting the safety of staff who engage in these activities. 26-13. CSC for FEP providers must have engage in the came members must include: 27-13. CSC for FEP providers and well-staff who engage in these activities. 28-13. CSC for FEP providers must have activities. 28-13. CSC for FEP providers and well-staff who engage in these activities. 28-13. CSC for FEP providers and practicioners are activities. 28-13. CSC for FEP providers and practicioners are activities. 28-13. CSC for FEP providers and practicioners are activities. 29-13. CSC for FEP providers and practicioners are activities. 29-13. CSC for FEP providers and practicioners are activities. 29-13. CSC for FEP providers and practicioners are activities. 29-13. CSC for FEP providers and practicioners are activities. 29-13. CSC for FEP providers and practicioners are activities. 29-13. CSC for FEP providers and practicioners are activities. 29-13. CSC for FEP providers and practicioners are activities. 29-13. CSC for FEP providers and practicioners are activities. 29-13. CSC for FEP providers and practicioners are activities. 29-13. CSC for FEP providers and
Individual may be discriarged due to drop out. 7. The CSC for FEP team must hold weekly team meetings. All CSC for individual must be discussed, even if only briefly. The purpose of the and the outcome of the most recent staff contacts, individuals' programmers.	Annividuals/families to any appropriate crisis services. individuals/families to any appropriate crisis services. 9. The CSC for FEP team should maintain a strong recovery orientatic cost for FEP providers must have established procedures/protocoteam in supporting and responding to CSC for FEP-enrolled individuate and responding to CSC for FEP-enrolled individual. 11. CSC for FEP providers must have a Coordinated Specialty Care for a Staffing pattern and how staff are deployed, including how use. Hours of operation and typical daily schedule for staff; c. Inter-team communication (e.g., e-mail, team staffing, staff; d. How the team will respond to crises for individuals served (e.g., e-mail, team supports, to the individuals whom the CSC for FEP team supports, to whenever possible, and this involvement should be document. f. Because of the often complex mental health conditions of C comprehensive mental health, addiction, and functional ass Status/Diagnosis, Physical Health, Substance Use, Educatic Relationships.	25-12. In addition to services provided to individuals enrolled in the progra community at large regarding behavioral health conditions, first epis and information on how to access the public behavioral health syste 26-13. CSC for FEP providers must have policies and procedures govern protecting the safety of staff who engage in these activities. 1. Coordinated Specialty Care team members must include: a. (1 FT Employee required): One full-time Team Leader who is the clinician on the team. The Team Leader must be a FT employe practitioner:

Required Components

44.1.CSC for FEP must include a comprehensive and integrated set of medical and psychosocial services provided in home, community, and office settings by a

Coordinated Specialty Care for First Episode Psychosis Program (CSC for FEP) (Effective Date January

multidisciplinary team.

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Staffing Requirements

Coordinated Specialty Care for First Episode Psychosis Program (CSC for FEP) (Effective Date January 1, 2023)

- i. Physician
- ii. Psychologist
- i. Physician's Assistant
 - ii. Triyaldan a Aas v. APRN
- /. RN with a 4-year BSN
- . LCSW
- ii. LPC
- iii. LMFT
- One of the following, as long as the practitioner below is under supervision in accordance with O.C.G.A. § 43-10A-11:
 - LMSW*
- LAPC*
- LAMFT*
- * If the team lead is not independently licensed, then clinical supervision duties should be delegated appropriately in accordance with expectations set forth in O.C.G.A. Practice Acts.
- (Variable: .25 FTE based on CSC for FEP team census of 30 participants): a prescriber (a psychiatrist or, under the supervision of a Psychiatrist, an APRN, NP, or PA) who: <u>.</u>
- Provides clinical and crisis services to all team participants;
- Works with the team to monitor each individual's clinical and medical status and response to treatment;
- Directs psychopharmacologic and medical treatment for CSC for FEP participants;
- Participates in the CSC for FEP team meetings weekly.
- (Variable: .15 FTE based on CSC for FEP team census of 30 participants): one Nurse (RN) who: ပ
- Provides nursing services for all participants, including health and assessments, education on treatment adherence, nutrition, exercise, smoking cessation, and other health and wellness-related topics as needed;
 - Works with the team to monitor each individual's overall physical health and wellness, clinical status and response to treatment; and
 - iii. Participants in the CSC for FEP team meetings weekly.
- If the Team Lead is not a licensed psychologist, LCSW, LPC, LMFT, LMSW, LAPC, or LAMFT, there must be an additional 0.5 FTE team member who holds one of these licensed credentials or associate licensed credentials (note that associate-level clinicians must be under supervision in accordance with O.C.G.A. § 43-10A-11). 6
- (1 FTE required): One full-time Case Manager who provides concrete needs assistance to CSC for FEP participants and who participates in the CSC for FEP team meetings weekly. The Case Manager is supervised by the Team Lead. œ̈
- vocational goals, and who participates in the CSC for FEP team meetings weekly. The Education and Employment Specialist is supervised by the Team Lead. (1 FTE required): One full-time Education and Employment Specialist who provides support to CSC for FEP participants on their educational and (1 FTE required): One or two Certified Peer Specialist or Certified Peer Specialist-Youth who are fully integrated into the team and promote
 - individual self-determination and decision-making and provide essential expertise and consultation to the entire team to promote a culture in which each participant's point of view and preferences are recognized, understood, respected and integrated into treatment and community integration activities. CPSs/CPS-Ys participate in the CSC for FEP team meetings weekly and are supervised by the Team Lead. တ်
- to utilize the Parent Peer Support service if a CPS-P is available, to meet the recovery needs of the family. This team member participates in the CSC for FEP participants. This practitioner bills the Parent Peer Support service (if a CPS-P) or Family Counseling/Training otherwise. The provider is strongly encouraged (Variable: 0.5 FTE based on CSC for FEP team census of 30 participants): One fully licensed or associate-level licensed clinician who specializes in family counseling, or a Certified Peer Specialist-Parent (CPS-P) who provides education, support, and training to family members of CSC for FEP team meetings weekly and is supervised by the Team Lead. ۲

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Coordinate	Coordinated Specialty Care for First Episode Psychosis Program (CSC for FEP) (Effective Date January 1, 2023) 1. Individuals receiving CSC for FEP do not need to have a qualifying diagnosis prior to the initial evaluation for eligibility for CSC for FEP enrollment. As stated above, it is anticipated that many youth and young adults referred to CSC for FEP teams will have had no previous mental health treatment and thus will not have received a diagnosis prior to their evaluation with the CSC for FEP teams.	
	2. Because CSC for FEP-eligible individuals may be difficult to engage, the initial treatment/recovery plan for an individual may be more generic at the onset of treatment/support. It is expected that the plan be individualized and recovery-oriented after the individual becomes engaged with the team. 3. Because many individuals served may have co-occurring mental health and substance use disorders, the CSC for FEP team may not discontinue services to individuals based solely upon a relapse in their substance use disorder recovery.	Case 1:
	 CSC for FEP teams are expected to participate actively and assertively in transitional planning for the individual, including: Via in person or, when in-person participation is impractical or not possible, via telephonic or virtual meetings between stakeholders; The team is expected to coordinate care through a demonstrable plan for timely follow-up on referrals to and from their service, making sure individuals are connected to resources to meet their needs in alignment with their preferences. 	16-cv-03
Clinical Operations	 c. The team is responsible for ensuring the individual has access to services and resources such as housing, pharmacy, benefits, a support network, etc. when being discharged from a psychiatric hospital; released from jail; or experiencing an episode of homelessness. d. CSC for FEP teams may use the Community Transition Planning service to establish a connection or reconnection to the individual and participate in discharge planning meetings while the individual is in a state operated hospital, crisis stabilization unit/behavioral health crisis center, jail/prison, or other community 	088-ELR
	psychiatric nospitat. e. When the nature of transition planning meets the scope of definition for either ADSS, CM, CTP, or CSI, that service should be billed in accordance with the particular scope of service defined within this Manual. 5. The CSC for FEP team is required to respond to the crisis needs of CSC for FEP-enrolled individuals, by either directly providing or referring individuals/families to any appropriate crisis services.	Docume
	6. Treatment and recovery support to the individuals served by the CSC for FEP team is provided in accordance with an individualized recovery plan, to be developed within 30 days of an individual's enrollment with the CSC for FEP team. Reviews of these plans should occur at least every six months and are thorough summaries describing the individual's and team's evaluation of the individual's progress/goal attainment, the effectiveness of the interventions provided, and the individual's satisfaction with services since the last plan review.	nt 448-73
Service Accessibility	 The CSC for FEP team must respond to phone calls from participants and family members 24-hours/365-days, and either directly provide or refer individuals/families to any appropriate crisis services. Answering devices/Services/Georgia Crisis and Access Line do not meet the expectation; CSC for FEP team staff members must provide this phone coverage. The team must be able to rapidly respond to early signs of relapse and symptom recurrence and must have the capability of providing multiple contacts daily to individuals in acute need. There must be documented evidence that service hours of operation include evening, weekend and holiday hours. 	Filed 11/29
Documentation Requirements	 Each CSC for FEP program must provide monthly fidelity and outcomes data as defined by the DBHDD. The CSC for FEP must have documentation (e.g., notebook, binder, file, etc.) of treatment team meetings to include: a. Date, start time, and end time for the meeting; b. Names of team participants involved in staffing (signed/certified by the team leader or team lead designee in the absence of the team leader); c. Initials all of individuals discussed/planned for during staffing; and d. Minimal documentation of content of discussion specific to each individual (1-2 sentences is sufficient). 3. CSC for FEP meeting logs should be retained for a minimum of one (1) year, and in accordance with professional standards and the provider agency's policy. 	9/23 Page 210
Billing & Reporting Requirements	2.1. Providers must document services in accordance with the general requirements found in Part II, Section III: Documentation Requirements of this Provider Manual, as well as with the service-specific requirements delineated in this section below. Service provision, billing, and reporting must adhere to all DBHDD and Georgia Collaborative ASO requirements.	of 627

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be billed/invoiced to the provider's DBHDD CSC for FEP contract. by Transition Planning as outlined in the guidelines for this service. I/prison. Inditure report and supporting documentation as needed to their de raid, managed care organizations, private insurance, etc.).	Code Detail	Presponder Program is established through a partnership between a contracted provider and one or more law enforcement agencies and/or emergency medical ices (EMS) entities to utilize the combined expertise of peace officers and behavioral health professionals on emergency calls involving behavioral health crises. goals of the program are to de-escalate crisis situations and help link individuals with behavioral health concerns to appropriate services. A Co-responder Program sists of the following components: Co-responder Teams: A team established pursuant to a co-responder program, composed of at least one officer team member and one dedicated CSB direct-service practitioner. Co-response Intervention: The Co-responder Team provides on-scene crisis de-escalation, screening and assessments, and referrals to ongoing treatment by the skilled staff named below. Post-emergency Follow-up Services: The contracted provider covering the area where the crisis occurred will contact the individual within two business days	"Co-responder Protocol Committee" to work to increase the availability, efficiency, and effectiveness of mmittee must consist of law enforcement agencies. subject of a communication-officer or public-safety dispatch interaction, and who could benefit from munity. The individual served does not have to be a current or past-enrolled recipient of DBHDD service.	e completed; d ed. n Services; Crisis Stabilization I
ed to the pri anning as o and supporti care organi	Rate	contracted pand behavior adividuals w program, co crisis de-es the area wh	er Protocol C consist of la communicat dividual serv	s situation ar s contact; an en documen ider Progran mergency D
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auspices of the CSC for FEP program. Education and employment support interventions should be billed/invoiced to the provider's DBHDD CSC for FEP contract. Education and employment support interventions should be billed/invoiced to the provider's DBHDD CSC for FEP team can provide and bill for Community Transition Planning as outlined in the guidelines for this service. This includes supporting individuals who are eligible for CSC for FEP and are transitioning from jail/prison. Providers must submit a monthly programmatic and expenditure report and supporting documentation as needed to their designated DBHDD programmatic officer. Providers must maximize use of third-party payers (Medicaid, managed care organizations, private insurance, etc.).	Code Detail	Co-Responder Program is established through a partnership between a contracted provider and one or more law enforcement agencies and/or emergency medical ervices (EMS) entities to utilize the combined expertise of peace officers and behavioral health professionals on emergency calls involving behavioral health crises. he goals of the program are to de-escalate crisis situations and help link individuals with behavioral health concerns to appropriate services. A Co-responder Program onsists of the following components: Co-responder Teams: A team established pursuant to a co-responder program, composed of at least one officer team member and one dedicated CSB direct-service practitioner. Co-response Intervention: The Co-responder Team provides on-scene crisis de-escalation, screening and assessments, and referrals to ongoing treatment by the skilled staff named below. Post-emergency Follow-up Services: The contracted provider covering the area where the crisis occurred will contact the individual within two business days	following a behavioral health crisis. Co-responder Protocol Committee: CSBs will establish a "Co-responder Protocol Committee" to work to increase the availability, efficiency, and effectiveness of community response to behavioral health crises. The Committee must consist of law enforcement agencies. dividuals experiencing a behavioral health crisis who are the subject of a communication-officer or public-safety dispatch interaction, and who could benefit from ehavioral health (BH) services and supports within the community. The individual served does not have to be a current or past-enrolled recipient of DBHDD services r supports.	. The acute presentation of the crisis situation is resolved; . Appropriate referral(s) and service engagement(s) to stabilize the crisis situation are completed; . Post-crisis follow-up contact has been completed within 2 days of crisis contact; and . Recommendations for ongoing services, supports or linkages have been documented Recommendations for ongoing services, supports or linkages have been documented In the following settings are excluded from receiving Co-Responder Program Services; Crisis Stabilization Units (CSU), Behavioral Health Crisis Centers and respiral (state or private); Residential Detox; Emergency Departments (EDs), state prisons; youth detention center, and Psychiatric Residential Treatment Facilities (PRTFs).

Co-Respon	Co-Responder Program													
Transaction Code	Code Detail	Code	Mod 1	Mod 2	Mod 3	Mod 4	Rate	Code Detail	Code	Mod 1	Mod 2	Mod 3	Mod 4	Rate
TBD	TBD	TBD												
Service Definition	 A Co-Responder Program is established through a partnership between a contracted provider and one or more law enforcement agencies and/or emergency medical services (EMS) entities to utilize the combined expertise of peace officers and behavioral health professionals on emergency calls involving behavioral health crises. The goals of the program are to de-escalate crisis situations and help link individuals with behavioral health concerns to appropriate services. A Co-responder Program consists of the following components: 1. Co-responder Teams: A team established pursuant to a co-responder program, composed of at least one officer team member and one dedicated CSB direct-service practitioner. 2. Co-response Intervention: The Co-responder Team provides on-scene crisis de-escalation, screening and assessments, and referrals to ongoing treatment by the skilled staff named below. 3. Post-emergency Follow-up Services: The contracted provider covering the area where the crisis occurred will contact the individual within two business days following a behavioral health crisis. 4. Co-responder Protocol Committee: CSBs will establish a "Co-responder Protocol Committee" to work to increase the availability, efficiency, and effectiveness of community response to behavioral health crises. 	olished through end combined through escalate or this established established Co-respondations: The crisis.	gh a pa experti: isis situ pursua der Tea contrac: will esta	rtnershirtnershirtnershirtnershirtners of perations of attions of the accordance of the proving the proving the proving the Cortical and a second the second th	ip betwee and helk and helk and helk and helk and helk and helk and des on-des on-ider co "Co-res mmittee mmittee	sen a complete and control in the co	ontracted principle of the behaviors dividuals with rogram, concrisis de-esc crisis de-esc he area when the area when one on sist of law	Presponder Program is established through a partnership between a contracted provider and one or more law enforcement agencies and/or emergency medical ices (EMS) entities to utilize the combined expertise of peace officers and behavioral health professionals on emergency calls involving behavioral health crises. goals of the program are to de-escalate crisis situations and help link individuals with behavioral health concerns to appropriate services. A Co-responder Program sists of the following components: Co-responder Teams: A team established pursuant to a co-responder program, composed of at least one officer team member and one dedicated CSB direct-service practitioner. Co-response Intervention: The Co-responder Team provides on-scene crisis de-escalation, screening and assessments, and referrals to ongoing treatment by the skilled staff named below. Post-emergency Follow-up Services: The contracted provider covering the area where the crisis occurred will contact the individual within two business days following a behavioral health crisis. Co-responder Protocol Committee: CSBs will establish a "Co-responder Protocol Committee" to work to increase the availability, efficiency, and effectiveness of community response to behavioral health crises. The Committee must consist of law enforcement agencies.	orcement a gency calls appropriat am membe nents, and i act the indiv	gencies involvir e servir r and o referral idual w ity, effic	s and/or	r emergrand vivioral Morares of the control of the	ency me earth cricalth cricalt	ses. rogram rct- by the
Admission Criteria	Individuals experiencing a behavioral health crisis who are the subject of a communication-officer or public-safety dispatch interaction, and who could benefit from behavioral health (BH) services and supports within the community. The individual served does not have to be a current or past-enrolled recipient of DBHDD services or supports.	ral health cri d supports v	isis who vithin th	are the	subjec nunity.	t of a c	ommunicatik ividual serve	ho are the subject of a communication-officer or public-safety dispatch interaction, and who could benefit from the community. The individual served does not have to be a current or past-enrolled recipient of DBHDD services	tch interacti t or past-en	on, and rolled r	d who c ecipien	ould be	nefit fro HDD se	m vices
Continuing Stay Criteria	N/A													
Discharge Criteria	 The acute presentation of the crisis situation is resolved; Appropriate referral(s) and service engagement(s) to stabilize the crisis situation are completed; Post-crisis follow-up contact has been completed within 2 days of crisis contact; and Recommendations for ongoing services, supports or linkages have been documented. 	crisis situatii vice engage as been com y services, si	on is reament(s) Inpleted upports	esolved; (s) to stak d within 2 ts or linka	oilize the days o	e crisis f crisis ve beer	situation are contact; and	ecompleted; 1 3d.						
Service Exclusions	Individuals in the following settings are excluded from receiving Co-Responder Program Services; Crisis Stabilization Units (CSU), Behavioral Health Crisis Centers (BHCC), CRR-I, psychiatric hospital (state or private); Residential Detox; Emergency Departments (EDs), state prisons; youth detention center; regional youth detention center, and Psychiatric Residential Treatment Facilities (PRTFs).	s are exclude al (state or p esidential T	ed from rivate); reatmer	receivir Reside nt Facili	m receiving Co-Respor); Residential Detox; E lent Facilities (PRTFs).	tesponc tox; En (TFs).	der Program nergency De	Services; Crisis Stabilization Lipartments (EDs), state prisons	nits (CSU), youth dete	Behav	ioral He enter; r	ealth Cr egional	isis Cen youth	ters

this manual via the Non-intensive Outpatient Services Type of Care. Each practitioner must follow the specific service definition for each service they bill under the 2. Non-intensive Outpatient services that are identified in the Service Definition section above should be authorized and billed in accordance with Part I, Section II of

auspices of the CSC for FEP program.

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Coordinated Specialty Care for First Episode Psychosis Program (CSC for FEP) (Effective Date January 1, 2023)

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Co-Respon	Co-Responder Program
Clinical	1. All individuals receiving Co-responder Program services must present with indications of a behavioral health disorder, an Intellectual/Developmental Disability,
Exclusions	and/or Substance Use Disorder. 2. Co-responder teams shall not respond to non-psychiatric medical emergencies.
	 Which programmatic requirements herein are required is contingent on the availability of funding. Variation on any expectations shall be defined in a specific DBHDD contract. a. Specifically, all Community Service Boards (CSBs) must provide: i. Follow-up Contact; and ii. Co-responder Protocol Committees
	 b. Additionally, contracted providers may provide: Co-responder Team/s; and Co-response Intervention. Contracted providers implementing a Co-responder Program are required to have documented evidence of the partnership between the local law enforcement partnersh in partnersh in the contracted provider establishing a co-responder program in their jurisdiction (e.g., co-signed plans, agreements, etc.). The agreement between the law enforcement agency/emergency medical services entity and the contracted provider should articulate, at minimum, the following: If the Co-responder Program partnership is with a Law Enforcement Agency, the following are requirements:
Required	 i. The commitment by a law enforcement agency to designate one or more peace officers to participate as officer team members in a co-responder team model; ii. Based on planned number of teams, the law enforcement agency's commitment to staff the required and named shifts for the co-responder team iii. That when an emergency call involving an individual's behavioral health crisis is received by a communications officer or public safety agency, and a Mobile Crisis Response Service is not appropriate or available, the communications officer should be encouraged to notify the co-responder team in the jurisdiction where the emergency is located, if practicable, regardless of whether other peace officers are also dispatched; iv. That the co-responder team will work collaboratively to de-escalate the situation; provided, however, that all final decisions shall be made by the officer
	team member, or by the officer's superiors. v. That during a co-responder team's response to a call, the law enforcement officer remains "in charge of the scene"; and vi. That the officer team member may consider input from the contracted provider team member in determining whether to refer an individual for behavioral health treatment or other community support, or to transport the individual for emergency evaluation in accordance with Code Section 37-3-42 or 37-7-42, rather than making an arrest; OR b. If the Co-responder Program partnership is with an Emergency Medical Services entity, the following are requirements: i. Based on planned number of teams, the Emergency Medicaid Services entity's commitment to staff the required and named shifts for the co-responder team
	 ii. That when an emergency call involving an individual's behavioral health crisis is received by a communications officer or public safety agency, and a Mobile Crisis Response Service is not appropriate or available, the communications officer should be encouraged to notify the co-responder team in the jurisdiction where the emergency is located, if practicable, regardless of whether other peace officers are also dispatched; iii. That the co-responder team will work collaboratively to de-escalate the situation; provided, however, that all final decisions shall be made by the EMT responder remains "in charge of the scene." iv. That during a co-responder team's response to a call, the EMT responder remains "in charge of the scene." c. Co-responder Teams and Interventions provided by the contracted provider shall comply with the following (which will also be documented in the shared agreement): i. The contracted providers will make available licensed and credentialed staff based on funding to support the co-responder teams designated shifts

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Co-Responder Program

- The co-responder licensed and/or credentialed staff may participate in-person or virtually via telemedicine or telephone.
 - The contracted provider team member/s will provide:
- Crisis behavioral health support/treatment;
- Referrals to and engagement with other medical and community supports;
- If licensed, and as appropriate, the contracted provider team member can issue a 1013/2013 to direct that an individual be taken to an emergency receiving facility for involuntary evaluation.
 - When an emergency call involving an individual with a behavioral health crisis is received by a law enforcement agency and a co-responder team is dispatched, a contracted provider team member shall either be available to accompany the officer team member in-person, or shall be available for consultation via telephone or telemedicine during the emergency call response .≥
 - Transport the individual for emergency evaluation in accordance with Code Section 37-3-42 or 37-7-42

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- individual's condition; provided, however, that the officer team member may authorize alternative transportation by a medical transport company or Transport conducted pursuant to this Code section shall occur in government-owned vehicles configured for safe transport based on the otherwise if deemed safe to do so based on the individual's condition.
- In the event that the officer team member transports the individual for emergency evaluation in accordance with Code Section 37-3-42 or 37-7-42 individual, regarding whether or not the individual is admitted for treatment, to identify and facilitate any necessary follow-up services for such to an emergency receiving facility which is a not a CSU, the officer shall notify the partnering contracted provider, prior to the release of the ςi
- The Co-responder team will provide known documentation for the individual and contact information for the contracted provider for the emergency receiving facility to contact for clinical continuity at discharge. ം
- resides for follow-up care. The Co-responder team will provide documentation regarding the intervention to the corresponding CSB for promoting clinical If the individual does not reside in the service area for the partnering contracted provider, the Co-responder team will notify a CSB where the individual ·<u>=</u>
- Post-emergency Follow-up Services რ.
- When a co-responder team responds to a behavioral health crisis, the assigned CSB for that service area where the crisis occurred shall contact the individual within two business days following the crisis.
 - The CSB who is providing the follow-up shall work to identify the types of services needed to support the individual's stability and to locate sources for those If the individual resides in another CSB's service area, the Co-responder teams shall communicate information about the individual to the appropriate community service board. <u>.</u> ပ
 - If the individual was incarcerated, the CSB may make recommendations for inclusion in a jail release plan. services, including peer support, housing, and job placement. 6

Following the behavioral health crisis, the CSB must provide voluntary outpatient therapy and rehabilitative supports, as needed, to eligible individuals

pursuant to Code Section 37-11-9. 4

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- committee will work with law enforcement agencies to increase the availability, efficiency, and effectiveness of community responses to behavioral health The CSB will establish a co-responder protocol committee comprised of the law enforcement agencies in their service area. The co-responder protocol Co-responder Protocol Committee (for law enforcement agency partnership models only): æ.
- Whether or not an agency chooses to participate in a co-responder team, each law enforcement agency in the service area shall designate an officer to serve crises, and to address issues arising from the work of co-responder teams. The co-responder protocol committee may include representatives of other agencies providing crisis responses and behavioral health care in the service area ю О
- Law enforcement agencies shall designate one officer to serve as the primary point of contact for the CSB. ပ

on the co-responder protocol committee.

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Rate

Mod

Co-Responder Program

The service begins with a CPS engaging individuals who are currently in an inpatient setting via the use of recovery dialogues (for example, sharing their own recovery processes, and promote a successful life of meaning and purpose in the community of each individual's choice. As the peer relationship progresses, the CPS supports story, building hope and exploring possibilities for recovery, and/or tapping into strengths individuals possess which could be used to galvanize the recovery process), among individuals transitioning from inpatient to community-based service settings. The goal of the service is to foster a positive and intentionally mutual relationship between a Certified Peer Specialist (CPS) and an individual to support his/her transition to the community and in regaining control over his/her own life and recovery Community Transition Peer Supports provide interventions that promote recovery, wellness, independence, self-advocacy, and the development of natural supports and gradually building mutually valued relationships with these individuals. Utilizing their unique lived experience, CPS role model the recovery journey, assist their peers in recognizing, understanding and relating their own recovery stories, support their peers in developing their own recovery goals and self-directed recovery Mod 7 $\frac{1}{2}$ Mod Mod ≥ $\stackrel{>}{\mathbb{H}}$ Code H0038 H0038 图 Practitioner Level 4, Out-of-Clinic Practitioner Level 5, Out-of-Clinic The contracted providers shall report data to the DBHDD in a format developed cooperatively with the contracted providers. Demonstrating and modeling recovery principles, self-help strategies, coping techniques, and self-advocacy; individuals in preparing for their return to the community and continues to support them during and after discharge. Code Detail identifying potential outcomes, opportunities, and challenges in accomplishing goals; In order to accomplish the goals of the service, supports such as the following are utilized: Rate Promoting the individual's self-articulation of his/her own recovery story; Mod providing support in meeting goals and objectives; Mod 90 Mod **C**2 4 Supporting effective coping skills development; the articulation of their personal goals; Transition Peer Supports (Peer Mentor) Mod \mathbb{A} Ă identifying personal strengths; Sharing one's own recovery story; Code H0038 H0038 Assisting individuals with: Practitioner Level 4, In-Clinic Practitioner Level 5, In-Clinic 6 Code Detail 15 minutes process. Requirements Peer Support **Fransaction Unit Value** Reporting Definition Services Service Code

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establishing and/or maintaining natural support systems.

if desired, the creation and ongoing maintenance of a personal Wellness Recovery Action Plan (WRAP);

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identifying and supporting participation in mutual self-help support groups;

:he development of problem-solving techniques;

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motivation and development of job-related skills;

community resource linking and acquisition;

identifying and overcoming their fears (i.e., in preparation for hospital discharge);

Due to the dual nature of the service setting (inpatient mittaily, then community-based as the individual transitions back to his/her own home and community), there are some interventions which are more germane to one setting or the other, and some interventions which are appropriate in both settings: For example, in the inpatient setting:
Establishment of an intentionally mutual relationship; Assisting with discharge preparation through shared experience; Assisting with discharge preparation through the use of Day-Passes (both on-site and off-site); Assisting with community connections through the use of Day-Passes (both on-site and off-site); Supporting the individual in setting and keeping goals relevant to the inpatient setting; Facilitating or assisting with interactions related to community resource linkage, discharge planning, and recovery dialogue (maximum of one group per week). a. General interaction with peers during social periods; b. Facilitate or assist groups on community resource linking, discharge planning, and recovery dialogue (maximum of one group per week).
mple, in the community setting: Ongoing building and support of an intentionally mutual relationship; Assisting with establishing and/or maintaining natural support systems; Assisting with social connections and community linkages.
nple, in both settings: Promoting the individual's self-articulation of his/her own recovery story; Demonstrating and modeling recovery principles, self-help strategies, coping techniques, and self-advocacy; Supporting the development or continuation of a self-directed recovery plan/process; Supporting effective coping skills and problem-solving skills development/utilization; Support in identifying and overcoming potential recovery barriers (i.e., fears, negative self-talk, stigma); Development and refinement of personal goals, and planning for how to achieve them
CTPS services are targeted to adults who meet the following criteria: a. Individual has a mental illness (and includes individuals with a co-occurring substance use disorder); b. Individual has little or no natural support systems that are actively engaged in encouraging wellness, empowerment, and self-advocacy; c. Individual wants to receive the CTPS service provided by a CPS; d. Individual has received extensive inpatient mental health services as evidenced by a prolonged stay (45 or more consecutive days) and/or frequent inpatient stays/readmissions; e. Individual may or may not currently be receiving forensic services.
Individual continues to meet admission criteria; and Progress notes document progress relative to goals identified in the Individualized Recovery/Resiliency Plan, but treatment/recovery goals have not yet been achieved.
 An adequate continuing recovery plan has been established; and one or more of the following: Goals and/or objectives in the Individualized Recovery/Resiliency Plan related to CTPS services have been substantially met; or Individual requests discharge; or Transfer to another service/level is more clinically appropriate.

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Service Exclusions	1. Individuals covered by a Medicaid Care Management Organization (CMO) are not covered for this DBHDD service benefit.
Clinical Exclusions	 Individuals diagnosed with a Substance-Related Disorder and no other concurrent mental illness; or Individuals with the following conditions are excluded from admission unless there is clearly documented evidence of a psychiatric condition co-occurring with one of the following diagnoses: Developmental Disability, Autism, Neurocognitive Disorder, or Traumatic Brain Injury.
Required Components	 CTPS services are primarily provided in 1:1 CPS to person-served ratio but may include one CTPS-related group per week. Individuals participating in the service at any given time must have the opportunity to participate in and make decisions about the person-centered interactions offered by the CPS.
Staffing Requirements	1. The providing practitioner is a Georgia-Certified Peer Specialist (CPS), though at the discretion of the Georgia Mental Health Consumer Network, may be hired conditionally with a time-based expectation that this requirement will be met.
Clinical Operations	1. The providing practitioner delivers all CTPS services under the auspices and supervision of the Georgia Mental Health Consumer Network.
Service Accessibility	 Service should initially be provided in a DBHDD inpatient setting, then shift to the individual's home and community setting upon discharge (any community setting is appropriate for providing the service so long as the choice of setting is made by the individual receiving the service). For the purposes of this definition, the word "inpatient" is inclusive of DBHDD hospitals and other high acuity supports such as Crisis Stabilization Units (CSUs) and Psychiatric Residential Treatment Facilities (PRTFs). If the individual is still admitted to the inpatient setting but is utilizing a day-pass, service may be provided outside of the inpatient setting. Service may be provided by telephone (although 50% must be provided face to face, telephonic contacts are limited to 50%). A CPS may facilitate no more than one CTPS-related group per week in the inpatient setting.
Documentation Requirements	1. CPSs must comply with any data collection expectations in support of the program's implementation and evaluation strategy.
Billing and Reporting Requirements	 For this service, the U6 In-Clinic modifier is utilized when the service occurs in a DBHDD inpatient setting, jail, or other institutional setting. For this service, the U7 Out-of-Clinic modifier is utilized when the service occurs outside a DBHDD inpatient setting or institution as referenced above.

Crisis Respir	Crisis Respite Apartments								
Transaction Code	Code Detail	Code	Mod 1	Mod 2	Mod 3	Mod 4	Rate		
Crisis Respite Service	Crisis Respite	H0045	뿦						
Unit Value	1 day				Utilization Criteria	Criteria		TBD	
Service Definition	The service offers crisis respite for an individual who needs a supportive environment facility, Crisis Stabilization Unit (CSU), or 23-hour observation area; or 2) when prever hour observation area and can be safely served in a voluntary community-based settir linkage to behavioral health treatment/supports and other community resources neces assistance when needed to access appropriate services, supports, and levels of care.	ual who needs a nour observatio ed in a voluntar ts and other col te services, sup	a supportiv n area; or y commu mmunity r ports, and	ve envirol 2) when nity-base esources d levels o	nment (1) w preventing d setting. C necessary f care.	then transiti an admissic risis Respit for the indiv	oning bad on or read s services vidual to s	The service offers crisis respite for an individual who needs a supportive environment (1) when transitioning back into the community from a psychiatric inpatient facility, CSU, or 23-facility, Cisis Stabilization Unit (CSU), or 23-hour observation area; or 2) when preventing an admission or readmission into a psychiatric inpatient facility, CSU, or 23-hour observation area and can be safely served in a voluntary community-based setting. Crisis Respite services include individualized engagement, crisis planning, linkage to behavioral health treatment/supports and other community resources necessary for the individual to safely reside in the community, including transportation assistance when needed to access appropriate services, supports, and levels of care.	
	where indicated in contract, the servic for individuals admitted to the service.	/Ice allows ror a e.	ın Ennanc	Sed CRA	сотропеп	. The ennar	ICED CRA	Where indicated in contract, the service allows for an Enhanced CKA component. The enhanced CKA provides increased on-site supervision requirements for individuals admitted to the service.	

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Crisis Respi	Crisis Respite Apartments	
	1. Individual with a severe and persistent mental illness that seriously interferes with their ability to live in the community <u>and</u> at least one of the below: a. Transitioning or recently discharged from a psychiatric inpatient setting; or b. Frequently admitted to a psychiatric inpatient facility or crisis stabilization unit (e.g., three (3) or more admissions within past 12 months or extended hospital	
	stay of 60 days within past 12 months); or c. Chronically homeless (e.g., 1 extended episode of homelessness for one year, or four (4) episodes of homelessness with three (3) years; or d. Recently released from iail or prison: or	Case
Admission Criteria	e. Indivic Indivic	1:16-c
	4. Individual (does not demonstrate danger to self or others) is able to safely remain in an open, community-based placement; and 5. Individual demonstrates need for short-term crisis support which could delay or prevent the need for higher levels of service intensity (such as acute	v-030
	nospitalization); and/or 6. Individual has a circumstance which destabilizes their current living arrangement and the provision of this service would provide short-term crisis relief and	88-E
	support. 7. Individuals discharging from a state hospital, presenting with an approved Notice to Proceed upon admission shall receive priority admission for a vacant CRA opening.	LR
	g g	Docu
Continuing Stay	a. Obtaining/applying for vital records; b. Submitting appropriate entitlement application;	men
Criteria	c. Documented housing search activities;	t 4
		48-
	e. Currently documented housing goal.	73
-	This service is short-term and transitional in nature, intended to support successful community transition and integration. As such, discharge planning begins upon admission.	F
Discharge Criteria	 Individual requests discharge; or Individual's medical necessity indicates a need for an alternate level of care; or Individual has received two consecutive episodes of care authorization; met the maximum length of stay. 	iled 11/
Service Exclusions	Intensive, Semi-Independent, and Independent Residential Services. Crisis stabilization unit services, community-based in-patient.	29/23
Clinical Exclusions	 Individuals experiencing a medical crisis are excluded from admission. Individuals with the following conditions are excluded from admission unless there is clearly documented evidence of a psychiatric condition co-occurring with a diagnosis of: Intellectual/Developmental Disabilities; and/or Autism; and/or Neurocognitive Disorder; and/or Traumatic Brain Injury. Danger to self or others. Active substance use as evidenced by positive drug and or alcohol screens. 	Page 2
	1. Upon admission into the CRA a housing plan must be in place that identifies the housing option or resource including action steps that will support transition within the maximum length of stay. All providers should develop a continuency plan in case the primary housing plan does not actualize.	18 o
Required Components	2. This service facilitates the provision of community supports that promote an individual's ability to prepare for and transition back into the community, including:	f 62
	 a. Comprehensive Needs Assessment; b. Linkage to appropriate behavioral health treatment and support services; 	7

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Crisis Respite Apartments C Practitioner Level 3: LCSW, LPC, LMFT, RN, MAC, CAADC, GCADC-II or – III, CAC-II (reimbursed at Level 4 rate). G Practitioner Level 4: LMSW, LAPC, LAMFT, Psychologist/LCSW/ILPC/LMFT's supervisee/trainee with at least a Bachelor's degree in one of the helping professions such as social work, community counseling, psychology, or criminology, functioning within the scope of the practice acts of the state, CPS (with Bachelor's Degree), Paraprofessional (with Bachelor's Degree), CPCRP (with Bachelor's Degree), or Certified Alcohol and Drug Counselor-Trainee (with Bachelor's Degree), or Certified Alcohol and Drug Counselor-Trainee (with Bachelor's Degree), or Certified Alcohol and Drug Counselor-Trainee (without Bachelor's Degree), or Certified Alcohol and Drug Counselor-Trainee (without Bachelor's Degree), or Certified Alcohol and Drug Counselor-Trainee (without Bachelor's Degree), or Certified Alcohol and Drug Counselor-Trainee (without Bachelor's Degree), or Certified Alcohol and Drug Counselor-Trainee (without Bachelor's Degree), or Certified Alcohol and Drug Counselor-Trainee (without Bachelor's Degree), and or of the practitioners cited below, must be under the documented supervision (organizational charts, supervisory notation, etc.) of an independently licensed/credentialed professional staff. C Certified Psychiatric Rehabilitation Professional. C Certified Addiction Counselor-I.	e. Certified Alcohol and Drug Counselor-Trainee. 3. Specific staffing requirements for each service provider are dependent upon how the service is integrated into an existing community-based service array and the providers' proposal for delivering the service. These requirements will be outlined in the provider-specific contracts and annexes.	 Not to exceed up to six (6) Crisis Respite beds located in a single integrated community setting. Crisis Respite is not accessible to individuals by walk-ins and there is no signage identifying the nature of this service. All individuals receiving Crisis Respite Services must come through a referring agency such as a Tier 1 or Tier 2 Provider, hospital, CSU, 23-hour observation area, emergency room, etc. Crisis Respite is not an emergency receiving facility and shall not receive individuals under emergency conditions. Any individual who presents under emergency receiving facility. Agency has a Crisis Respite Service Organizational Plan that addresses the following: Description of the staffing pattern and how staff are deployed to a secure that the required staff to individual ratios. 	 a. Description of the starting pattern and now start are deployed to assure that the required start-to-individual ratios are mission of the starting pattern and now start are accommodated, case mix, access, etc.; b. Description of the hours of operations as related to access and availability to the individuals served; c. Description of how the IRP? plan constructed, modified and/or adjusted to meet the needs of the individual and to facilitate broad natural and formal support participation; and d. Description of how Crisis Respite Service agency engages with other agencies who may serve the target population. e. Description of protocol to secure the individual's personal items including medications. 4. For the individual connected to a behavioral health provider, the Crisis Respite staff shall engage the behavioral health provider, the Crisis Respite staff shall engage the behavioral health provider. 	meeting treatment and medication needs during brief respite period. For the individual not connected to a behavioral health provider, the Crisis Respite staff shall engage and link that individual to behavioral health services upon admission. Every individual will be assisted in developing a crisis plan at the time of admission or the individual's existing crisis plan will be reviewed in concert with existing behavioral health provider and updated as needed. 7. To promote privacy, there will be no external signage to indicate the presence of a behavioral health service. 8. Program staff shall introduce concepts of independent living to the individual and promote activities to advance goals of successful, individualized, community-integrated housing.
dse				
Crisis R			Clinical Operations	

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Crisis Respi	Crisis Respite Apartments		
Service Accessibility Reporting and Billing Requirements Additional Medicaid Requirements	 Referrals must be accepted daily during agency hours of operation, minimally between the hours of 9 am and 5 pm. Providers should communicate an admission decision and move-in date within 3 business days of receiving a referral. When vacancies exist, referrals and admissions must be accepted 7 days per week. Each provider is responsible for establishing a system with priority referral sources (hospitals, CSUs, Crisis Service Centers, Temporary Observation units, emergency rooms, Mobile Crisis Team) through which the status of bed availability is accessible to referral sources 24 hours per day. This may be though a website or automated phone greeting. The average length of stay shall not exceed two consecutive authorizations of care approved by the ASO. This service incorporates linkage to choices for housing which reflect individualized needs, preferences, as well as appropriate and available housing options. Span billing may occur for this service, meaning the start and end date are not the same on a given service claim line; however, spans cannot cross months (e.g. start date and end date must be within the same month). The provider must submit billing and reporting according to annual contract requirements. Not a Medicaid-billable service.	ten the hours of 9 am and 5 pm. Providers should communicate an admission stroies exist, referrals and admissions must be accepted 7 days per week. hospitals, CSUs, Crisis Service Centers, Temporary Observation units, s accessible to referral sources 24 hours per day. This may be though a approved by the ASO. Ineeds, preferences, as well as appropriate and available housing options. ame on a given service claim line; however, spans cannot cross months (e.g. nents.	Case 1:16-cv-03088-ELR
Crisis Service Center Transaction Code Detail	ce Center Code Detail	Code Mod Mod Mod Rate	Docur
Crisis Service Center	Crisis Service Center (CSC)	2	nent 4
Unit Value	1 day (contact)	Utilization Criteria TBD	48
Service Definition	e Center (CSC) provides short-term, 24/7, in the is experiencing an abrupt and substantian narked increase in personal distress. These not in crisis but who are seeking access to on of the facility provided by a licensed profe is situation may include assessment of crisi situation gigns of crisis related behavior; assivaming signs of crisis related behavior; assivaming and interventions; referral to appropriate ed necessary to effectively manage the crisis.	'acility-based, walk-in psychiatric/substance related crisis evaluation and brief intervention services to support all change in behavior noted by severe impairment of functioning typically associated with a precipitating services also include screening and referral for appropriate outpatient services and community resources for behavioral health care. Interventions are provided by licensed and unlicensed behavioral health professionals, is sional and designed to prevent out of community treatment or hospitalization. Interventions used to designed to prevent out of community treatment or hospitalization. Interventions used to designed to active problem stance to, and involvement/ participation of the individual (to the extent he/she is capable) in active problem is levels of care for adults experiencing crisis situations which may include a crisis stabilization unit or other is; to mobilize natural support systems; and to arrange transportation when needed to access appropriate	3-73 Filed 11/29/23
Admission Criteria	 Adult with a suspected or known mental illness diagnosis or substance related disorder; AND Expressing a need for behavioral healthcare services; OR Experiencing a severe situational crisis; OR At risk of harm to self, others, and/or property. Risk may range from mild to imminent; and at least one of the following; Individual has insufficient or severely limited resources or skills necessary to cope with the immediate crisis; or Individual demonstrates lack of judgment and/or impulse control and/or cognitive/perceptual abilities which are necessary to cope with immediate crisis. 	ar; AND and at least one of the following; with the immediate crisis; or erceptual abilities which are necessary to cope with immediate crisis.	Page 221 of
Continuing Stay Criteria	Not applicable, as this service is intended to be a discrete time-limited service that stabilizes the individual and moves them to the appropriate level of care.	zes the individual and moves them to the appropriate level of care.	627

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Crisis Service Center	Crisis situation is resolved and/or referral to appropriate service is provided.	No exclusions. However, if the individual is enrolled in ACT, it is the expectation that the ACT provider serves as the primary crisis response resource.	 A stand-alone Crisis Service Center (not co-located with or within a facility that is a Behavioral Health Crisis Center (BHCC)) is not an emergency receiving facility and shall not receive individuals under emergency conditions. Any individual who presents under emergency conditions (1013/213/probate court order) to a standalone CSC must be directed to the nearest available emergency receiving facility. If a CSC operates as part of a Behavioral Health Crisis Center (BHCC), the CSC (or the associated Temp Observation or CSU service) must accept individuals referred under emergency conditions (1013/2013/probate court order) and perform a face-to-face evaluation in order to determine the most appropriate level of care. If after face-to-face assessment by licensed staff, if it is determined that the severity individual requires services at a different level of care, the CSC will make the necessary referrals and/or arrangements for transfer to an appropriate level of care. 	Crisis Service Center is a facility-based service which is operational 24 hours a day, 7 days a week, offering a safe environment for individuals receiving crisis assessments, stabilization, and referral services using licensed mental health professionals.	 A. At a minimum, staff must include: 1. A fully Licensed Behavioral Health Clinician on site at all times; 2. A Certified Peer Specialist – coverage may be shared with the temporary observation unit; 3. A Physician, APRN or PA to provide timely assessment, orders for presenting individuals, and temporary observation (coverage may be shared with a Crisis Service Center or Crisis Stabilization Unit as long as contract requirements for coverage by specific levels of professionals are met); and 4. A Registered Nurse who is stationed in the Temporary Observation Unit may float to the Crisis Service Center to perform nursing assessments. B. A DBHDD contract for this service may list additional staffing requirements. In the event of conflicting requirements, provider must adhere to the requirement that is most stringent. 	 All Physicians, Physician Assistants, and Advanced Practice Registered Nurses are under the supervision of a board-eligible Psychiatrist who provides direction, supervision and oversight of program quality. On-Call Physicians, Physician Assistants, or Advanced Practice Registered Nurses must be within 1 hour of initial contact by CSC staff. Response time for On-Call Physician Assistants, or Advanced Practice Registered Nurses must be within 1 hour of initial contact by CSC staff. Medication must be administered by licensed or credentialed* medical personnel under the supervision of a physician or registered nurse in accordance with O.C.G.A. 	This service is available 7 days a week, 24 hours a day.	Providers must report information on all individuals served in CSC no matter the funding source: 1. The CSC shall submit prior authorization requests for all individuals served (state-funded, Medicaid funded, party payer, etc.); 2. The CSC shall submit per diem encounters (1 per day) for service (S9484) for all individuals served (state-funded, Medicaid funded, private pay, other third-party payer, etc.) even if sub-parts cited in type of care P0015 are billed as a claim to Medicaid or other payer source; and payer, etc.) even if sub-parts cited in type of care P0015 are billed as a claim to Medicaid or other payer source; and or other for service (1 calendar day) following the start of services and must document this exception on the Order noting the name of the staff member responsible for obtaining the Order for service. 4. The Chisis Service Center should bill individual discrete services for DBHDD state-funded and Medicaid FFS service recipients. There is a Crisis Services Type of Care available for use by Crisis Service Centers (stand-alone and within a BHCC). 5. The individual services listed below may be billed up to the daily maximum listed for services provided in the Crisis Service Center. Billable services in the Crisis Service Center are as follows:
Crisis Ser	Discharge Criteria	Service Exclusions	Clinical Exclusions	Required Components	Staffing Requirements	Clinical Operations	Service Accessibility	Reporting and Billing Requirements

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		tion	E

Vervice	Max Daily Units
Behavioral Health Assessment & Service Plan Development	12
Psychological Testing	5
Diagnostic Assessment	2
Interactive Complexity (as a modifier to Psychiatric Treatment, Diagnostic Assessment, Individual Counseling, and Group Counseling)	4
Crisis Intervention	14
Psychiatric Treatment	2
Nursing Assessment & Care	14
Medication Administration	1
Psychosocial Rehabilitation - Individual	8
Addictive Disease Support Services	16
Individual Outpatient Services	_
Family Outpatient Services	4
Case Management	12
Peer Support - Individual	8

Crisis Stabil	Crisis Stabilization Unit (CSU) Services	ses												
Transaction Code	Code Detail	Code	Mod 1	Mod 2	Mod 3	Mod 4	Rate	Code Detail	Code	Mod 1	Mod Mod Mod Mod	Mod 3	Mod 4	Rate
Behavioral Health; Short- term Residential (Non-Hospital Residential Treatment Program W/o Rm & Board, Per Diem)		H0018					209.22	Behavioral Health; Short-term Residential (Non- Hospital Residential Treatment Program W/o Rm & Board, Per Diem)	H0018	178	U2			Per negotiation
Unit Value	1 day							Utilization Criteria	LOCUS Levels 5 and 6	Levels	5 and 6			
	This is a residential alternative to or diversion from inpatient hospitalization, offering psychiatric stabilization and withdrawal management services. The program	or diversio	on from i	npatient	hospital	lization, c	offering psychiatri	stabilization and wit	hdrawal ı	nanage	ment se	rvices.	The pr	ogram
	provides medically monitored residential services for the purpose of providing psychiatric stabilization and substance withdrawal management services on a short-term	dential se	rvices fo	r the pur	rpose of	providing	g psychiatric stab	lization and substand	e withdra	wal ma	nageme	nt servi	ces on	a short-term
Service	basis. Services may include (see Behavioral Health Provider Certification and Operational Requirements for Certified Crisis Stabilization Units (CSUs), 01-325).	Behavior	al Health	Provide	er Certifi	cation ar	d Operational Re	quirements for Certifi	ed Crisis	Stabiliz	ation Un	its (CS	Us), 01	<u>-325</u>):
Definition	a. Psychiatric, diagnostic, and medical assessments;	c, and me	dical ass	essmen	ts;									
	b. Crisis assessment, support and intervention;	ipport and	interver	tion;										
	c. Medically Monitored Residential Substance Withdrawal Management (at ASAM Level 3.7-WM);	Residentia	I Substa	nce With	drawal	Manager	nent (at ASAM Le	vel 3.7-WM);						

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d. Medication Unit (CSU) Services d. Medication administration, management and monitoring; e. Psychiatric/Behavioral Health Treatment; f. Nursing Assessment and Care; g. Brief individual, group and/or family counseling; and h. Linkage to other services as needed. 1. Treatment at a lower level of care has been attempted or given serious consideration; and 2. Individual has a known or suspected illness/disorder in keeping with one of the following target populations: An adult who is experiencing a: a. Severe situational crisis, or b. Mental Illness: or	 c. Substance Use Disorder; or d. Co-Occurring Substance Use Disorder and Mental Illness; or e. Co-Occurring Mental Illness and Intellectual/Developmental Disability; or f. Co-occurring Substance Use Disorder and Intellectual/Developmental Disability; and 3. Individual is experiencing a severe situational crisis which has significantly compromised safety and/or functioning; as evidenced by one or more of the 	a. Individual presents a substantial risk of harm to self, others, and/or property or is so unable to care for his or her own physical health and safety as to create a life-endangering crisis. Risk may range from mild to imminent; or b. Individual has insufficient or severely limited resources or skills necessary to cope with the immediate crisis; or c. Individual demonstrates lack of judgment and/or impulse control and/or cognitive/perceptual abilities to manage the crisis; or d. For withdrawal management services, individual meets diagnostic criteria under the DSM for substance use, exhibiting withdrawal signs, symptoms, behaviors, or functional impairments and can reasonably be expected to respond to withdrawal management.	This servi	 Individual no longer meets admission guidelines requirements; or Crisis situation is resolved and an adequate continuing care plan has been established; or Individual does not stabilize within the evaluation period and must be transferred to a higher intensity service. 	This is a comprehensive service intervention that is not to be provided with any other service(s), except for the following: a. Methadone Administration. b. Crisis Services Type of Care.	 Individual is not in crisis. Individual does not present a risk of harm to self or others or is able to care for his or her own physical health and safety. Severity of clinical issues precludes provision of services at this level of intensity. See <u>CSU: Medical Evaluation Guidelines and Exclusion Criteria for Admission to Crisis Stabilization Units</u>, 01-350. 	 Crisis Stabilization Units (CSU) providing medically monitored short-term residential psychiatric stabilization and withdrawal management services shall be designated by DBHDD as both an emergency receiving facility and an evaluation facility and must be surveyed and licensed by the DBHDD. In addition to all service qualifications specified in this document, providers of this service must adhere to Behavioral Health Provider Certification and Operational Requirements for Certified Crisis Stabilization Units (CSUs), 01-325. Individual referred to a CSU must be evaluated by a physician within 24 hours of the referral. Services must be provided in a facility designated as an emergency receiving and evaluation facility.
	Admission Criteria		Continuing Stay Criteria	Discharge Criteria	Service Exclusions	Olinical Exclusions	Required Components

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Crisis Stabil	 Crisis Stabilization Unit (CSU) Services 5. All services provided within the CSU must be delivered under the direction of a physician. A physician must conduct an assessment of new admissions, address issues of care, and write orders as required. 6. Crisis Stabilization Units (CSU) must continually monitor the bed –board, regardless of current bed availability, and review, accept or decline individuals who are awaiting disposition on a bed-board, and provide a disposition based on clinical review. It is the expectation that CSU's accept the individual who is most in need. 7. CSUs are expected to review, accept or decline at least 90% of all individuals placed on a bed-board over the course of a fiscal year. 	new admissions, address ecline individuals who are /idual who is most in need.	Cas
	 A physician—to-physician consultation is required for all CSU denials that occur when that CSU has an open/available bed. Crisis Stabilization Unit (CSU) Services must be provided by a physician or a staff member under the supervision of a physician, practicing within the scope of State law. A CSU must employ a fulltime Nursing Administrator who is a Registered Nurse. A CSU must have a Registered Nurse present at the facility at all times. If the charge nurse is an ADRN, then helds may not similitation by services the processible physician during the same shift. 	sing within the scope of	e 1:16-cv-03
Staffing Requirements	. 6.65	h rules and regulations. al Nurses must be o services, skills building,	8088-ELR
	8. 8.A CSU that functions as a component of a Behavioral Health Crisis Center (BHCC) must employ a full-time peer specialist (MH, CPS-AD) during the hours of 8:00 AM to 10:00 PM seven (7) days per week.	-AD) during the hours of	Docu
	 CSU must have documented operating agreements and referral mechanisms for psychiatric disorders, substance use disorders, and physical healthcare needs that are beyond the scope of the CSU and that require inpatient treatment. Operating agreements must delineate the type and level of service to be provided by the private or public inpatient hospital or treatment facility. These agreements must specifically address the criteria and procedures for transferring an individual to a designated treatment facility when the CSU is unable to stabilize the individual. CSUs must follow the seclusion and restraint procedures included in DBHDD's policy: CSU: Use of Seclusion or Restraint in Crisis Stabilization Services, 01-351. The following restraint practices are prohibited: 	ysical healthcare needs ervice to be provided by ransferring an individual to ilization Services, 01-351.	ument 448-73
Clinical Operations	ရော် ပေး ဗော် မေး ကော်မေး .		Filed 11/29/23
	 I he use of medication as a chemical restraint. For individuals with co-occurring diagnoses including developmental disability/developmental disabilities, this service must target the symptoms, manifestations, and skills-development related to the identified behavioral health issue. Individuals served in transitional beds may access an array of community-based services in preparation for their transition out of the CSU and are expected to engage in community-based services daily while in a transitional bed. Medication must be administered by licensed or credentialed* medical personnel under the supervision of a physician or registered nurse in accordance with O.C.G.A. 	nptoms, manifestations, U and are expected to e in accordance with	Page 225 of 627

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Crisis Stabill	Zal	Crisis Stabilization Unit (CSU) Services
Additional	-	1. Crisis Stabilization Units with 16 beds or less may bill services to GAMMIS for Medicaid FFS recipients.
Medicaid	5.	Medicaid claims for this service may not be billed for any service provided to Medicaid-eligible individuals in CSUs with greater than 16 beds.
Requirements		
	-	This service requires authorization via the ASO via GCAL. Providers will select an individual from the State Contract Bed (SCB) Board. Once they accept them,
		they will assign the individual to a bed on the inventory status board (via bhlweb). Once an individual is assigned to the inventory status board a tracking number
		will be generated and the information will be sent from the Georgia Collaborative ASO crisis access team to the Georgia Collaborative ASO care management
		team for registration/authorization to take place. Once an authorization number is assigned, that number will appear on the beds inventory status board (on
		bhlweb) and an email will be generated and sent to the designated UM of the SCB facility containing the authorization number.
Billing &	2	Providers must report information on all individuals served in CSUs no matter the funding source:
Reporting	რ	The CSU shall submit prior authorization requests for all individuals served (state-funded, Medicaid funded, private pay, other third-party payer, etc.);
Requirements	4.	The CSU shall submit per diem encounters (H0018 or H0018) for all individuals served (state-funded, Medicaid-funded, private pay, other third-party payer, etc.).
	5.	Providers must designate either CSU bed use or transitional bed use in encounter submissions through the presence or absence of the TB modifier. TB
		represents "Transitional Bed."
	6.	Unlike all other DBHDD residential services, the start date of a CSU span encounter submission may be in one month and the end date may be in the next. The
		span of reporting must cover continuous days of service and the number of units must equal the days in the span.
	7.	Providers must submit a discharge summary into the provider connect/batch system within 72 hours of CSU discharge.
	.	1. Individuals receiving services within the CSU shall be reported as a per diem encounter based upon occupancy at 11:59PM. At 11:59PM, each individual reported
		must have a verifiable physician's order for CSU level of care [or order written by delegation of authority to nurse or physician assistant under protocol as specified
000tatata		in § 43-34-23]. Individuals entering and leaving the CSU on the same day (prior to 11:59PM) will not have a per diem encounter reported.
Poduirements	2	For individuals transferred to transitional beds, the date of transfer must be documented in a progress note and filed in the individual's chart.
	က်	In addition to documentation requirements set forth in Part II of this manual, the notes for the program must have documentation to support the per diem including
		admission/discharge time, shift notes, and specific consumer interactions.
	4.	Daily engagement in community-based services must also be documented in progress notes for those occupying transitional beds.

Capacity	Code Mod Mod Mod Rate	Per negotiation		to, and diversion from inpatient hospitalization for adults with a co-occurring behavioral health condition (i.e. a mental	Ilness and/or substance use disorder) and Intellectual/Developmental Disability (I/DD) who present with crisis-related psychiatric/substance use disorder symptoms
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Specia	Mod N	TB UZ	evels 5 a	behavio	ric/subs
(QQ/I	ope	H0018	T SNOC	curring	psychiat
ility (Ö		ia L(1 a co-o	-related
ital Disab	Code Detail	Behavioral Health; Short-term Residential (Non- Hospital Residential Treatment Program W/o Rm & Board, Per Diem)	Utilization Criteria LOCUS Levels 5 and 6	or adults with	nt with crisis
pmen	<u>ප</u>	e S S S S S S S S S S S S S S S S S S S	Ţ	ization f	o prese
& Develo	Rate	Behavioral Short-term Short-term Residential Hospital Per negotiation Residential Treatment Program W. & Board, Pe. Diem)		atient hospital	ility (I/DD) wh
ectual	Mod 4			rom inpa	al Disab
Intelle	Mod 3			rersion f	lopment
ırring	Mod Mod Mod Rate			, and div	ual/Deve
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s - Co	Code Mod	H0018		tial alter	er) and
ervice		_		residen	e disord
SU) S				ort-term	ance us
nit (C				is a sh	or subst
ization Ur	Code Detail		1 day	This service is a short-term residential alternative t	illness and/c
Crisis Stabilization Unit (CSU) Services - Co-Occurring Intellectual & Developmental Disability (I/DD) Specialized Capacity	Transaction Code	Behavioral Health; Short- term Residential (Non-Hospital Residential Treatment Program W/o Rm & Board,	Unit Value	Service	Definition

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To provide medically monitored residential psychiatric and/or substance use disorder stabilization (e.g., substance withdrawal management services), and/or behavior stabilization (e.g. utilizing individualized applied behavior interventions and other behavior support services), in order to ameliorate the symptoms and/or challenging behaviors that place the individual or others at serious risk; 2. To increase communication skills and adaptive skills to help mitigate crisis-related challenging behaviors; and 3. To increase the caregiver's (if applicable) ability to support the individual in the community. The CSU must perform crisis-related assessments of each individual served, as clinically indicated. At a minimum, these assessments must include a psychiatric and SUD-related assessment (including a Diagnostic Assessment), and a medical assessment, environmental/situational/needs assessment, adult ANSA-I/DD may include but are not limited to: Functional behavior assessment, adaptive skills assessment, environmental/situational/needs assessment, adult ANSA-I/DD version, etc.	Je j	 Medically Monitored Residential Substance Withdrawal Management (at ASAM Level 3.7-WM); Medication administration, management, and monitoring; Psychiatric/Behavioral Health Treatment; Applied Behavior Analysis (ABA) and other crisis-oriented behavior support interventions; 	 6. Nursing Assessment and Care; 7. Brief individual, group, and/or family counseling; and 8. Formal/natural support training in ABA and/or other behavior support interventions; and 9. Discharge planning and linkage to other services as needed, and follow-up. 	 Treatment at a lower level of care has been attempted or given serious consideration; AND 	 Individual is an adult who has a known or suspected illness/disorder in keeping with one or more of the following: Co-Occurring Mental Illness and Intellectual/Developmental Disability; and/or Co-occurring Substance Use Disorder and Intellectual/Developmental Disability; AND 	3. The individual is experiencing a severe crisis (situational, psychiatric, and/or substance use-related), which includes an increase in severe and challenging maladaptive behaviors, <u>and/or</u> a lack of sufficient adaptive skills to manage the crisis at the individual's current level of care/support; and an As a result of the crisis, the individual's safety and/or functioning have been significantly compromised beyond any safety/functional challenges that are		Individual Sability to safety refinal in the fronte/community, of 3. The individual either displays high acuity maladaptive behavior, or fails to display necessary adaptive skill, which impact the individual's ability to function in significant life domains: family, work, school, social, or activities of daily living. The impact on functioning seriously and imminently compromises the individual's ability to remain safely in the community, or to be supported at a lower level of care; and

and/or severe and challenging behaviors related to an I/DD. These symptoms and/or behaviors seriously and imminently compromise health, safety, baseline daily

functioning, and/or ability to remain in the community. The main goals of this service are:

Crisis Stabilization Unit (CSU) Services - Co-Occurring Intellectual & Developmental Disability (I/DD) Specialized Capacity

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Crisis Stabili Continuing Stay Criteria Discharge Criteria Service Exclusions	<u>r </u>	Crisis Stabilization Unit (CSU) Services - Co-Occurring Intellectual & Developmental Disability (I/DD) Specialized Capacity D. The individual requires crisis behavior intervention and/or an increased level of support/monitoring (such as a need for additional and/or specialized staff oversight) that cannot be achieved at a lower level of care, or within the standard behavioral health millieu of the Crisis Stabilization Unit. 1. Individual continues to meet admission criteria as defined above; and 2. If clinically indicated applicable, a behavior support plan for the crisis-related maladaptive behavior has been created/updated and implemented, but the behavior has not stabilized to the extent that the individual can safely return to his or her home/community; and 3. A higher level of care is not indicated. 1. Individual no longer meets admission criteria and an adequate discharge/continuing support/care plan has been established; and Individual Discharge can be safely supported at either a lower level of care or in his/her natural home/setting. Discharge 2. Individual supported at either a lower level of care or in his/her natural home/setting. A. Individual's crisis-related severe maladaptive behaviors and/or behavioral health symptoms have not stabilized within the crisis stabilization period, and individual must be transferred to a service offering a longer duration of intensive treatment or a higher level of care. C. Opioid Manitenance Treatment. 3. A higher level of care or on intervention planting of Discharge and Di	Case 1:16-cv-03088-ELR Documer
	7	All other Medicard-Termbursable and DBHDD State-Funded Intellectual and Developmental Disability services are excluded, with the exceptions of Support Coordination, Fiscal Intermediary services, Waiver Supplemental Services, and training of formal and natural supports regarding the behavior support plan (if applicable).	nt 448-7

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Crisis Stabil	llizat	Crisis Stabilization Unit (CSU) Services - Co-Occurring Intellectual & Developmental Disability (I/DD) Specialized Capacity	
	← ८′ რ	Individual is not in crisis. Individual is self or others or is able to care for his or her own physical health and safety. Severity of of harm to self or others or is able to care for his or her own physical health and safety. Severity of clinical issues precludes provision of services at this level of intensity. See CSU: Medical Evaluation Guidelines and Exclusion Criteria for Admission.	
	4.	to Crisis Stabilization Units, 01-350. EXCEPTIONS: While some of the following are exclusionary in accordance with standard CSU policy, the items below are not exclusionary criteria for this	Cas
		targeted service: a. Medical Needs: i ADI s: Inability to independently perform ADI s, as defined below, is not an exclusion criterion for this service. An individual's dependence is defined as	e 1:10
Olinical		staff supervision, direction/prompts, and personal assistance. 1 Transferring: The extent of an individual's ability to move from one position to another	6-cv-
Exclusions		2. Feeding: The ability of an individual to feed oneself. 3. Draceing: The ability to select appropriate clothes and nut clothes on	0308
			38-EI
		مَ	LR
			Do
		c. Elopement Risk: Elopement behavior is <u>not</u> an exclusionary criterion for this service. Individual may have recent or historical episodes of elopement	ocu
		benaviors tnat nave placed the individual at imminent risk to self or others. d. Physical characteristics alone (e.g., height, weight, etc.) do not preclude admission.	me
	-	Crisis Stabilization Units (CSU) providing medically monitored short-term residential psychiatric/behavioral stabilization and withdrawal management services shall	nt 4
	c	be designated by DBHDD as both an emergency receiving facility and an evaluation facility and must be surveyed and licensed by the DBHDD.	148
	7	In addition to all service qualifications specified in this document, providers of this service must adhere to <u>Benavioral Health Provider Certification and Operational</u> Requirements for Certified Crisis Stahilization Units (CSUs) 01-325	8-73
	<i>ب</i>	Individual referred to a CSU must be evaluated by a physician within 24 hours of the referral.	3
	4. 1		Fil
Required	က်	All services provided within the CSU must be delivered under the direction of a physician. A physician must conduct an assessment of new admissions, address	led
Components	9	issues of care, and write orders as required. Crisis Stabilization Units (CSU) must continually monitor the bed-board, regardless of current bed availability, and review, accept or decline individuals who are	11
	١	awaiting disposition on a bed-board, and provide a disposition based on clinical review. It is the expectation that CSU's accept the individual who is most in need.	/29/
	. ∞	CSUS are expected to review, accept or decline at least 90% or all individuals placed on a bed-board over the course of a fiscal year. A physician–to-physician consultation is required for all CSU denials that occur when that CSU has an open/available bed.	/23
	о́	Aftercare planning: The CSU must notify the appropriate DBHDD Field Office of an individual's admission within two (2) business days, particularly for individuals who may not have needed services, supports, or living arrangements post-discharge.	Р
	-	ilization Unit (CSU) Services must be provide	age
	,	State law.	22
Staffing Requirements	∾ ∾	A CSU must employ a fulltime Nursing Administrator who is a Registered Nurse. A CSU must have a Registered Nurse present at the facility at all times	9 o
	4.	If the charge nurse is an APRN, then he/she may not simultaneously serve as the accessible physician during the same shift.	f 62
	2.	Staff-to-individual served ratios must be established based on the stabilization needs of individuals being served and in accordance with rules and regulations.	7

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	6. Functions performed by Physician Assistants, Nurse Practitioners, Clinical Nurse Specialists performed within the scope of practice allowed by State law and Professional Practice Acts. 7. CSUs are encouraged to employ a CPS as part of their regular staffing compliment and utilities.	Functions performed by Physician Assistants, Nurse Practitioners, Clinical Nurse Specialists, Registered Nurses, and Licensed Practical Nurses must be performed within the scope of practice allowed by State law and Professional Practice Acts.	
		ooos ale enconaged o employ a cro as parror riell regulai starmi g compliment, and diffice meny engagement, orientation to services, skills building, WRAP development: discharge planning and aftercare follow-up.	(
	8. A CSU that functions as a component of a Behavioral Health Cris	A CSU that functions as a component of a Behavioral Health Crisis Center (BHCC) must employ a full-time peer specialist (MH, CPS-AD) during the hours of 8:00	Case
	AM to 10:00 PM seven (7) days per week. 9. The Co-Occurring I/DD Specialized Capacity CSU must employ.	employ, at a minimum, one half-time-equivalent (FTE) Board Certified Behavior Analyst (BCBA) who	e 1 :
		serves as the lead for all Applied Behavior Analysis (ABA) aspects of treatment, and provides oversight to direct care staff engaged in ABA or other behavior	:16-
	support interventions. Functions performed by the BCBA may be their professional standards	support interventions. Functions performed by the BCBA may be partially provided via telemedicine, however, all functions must be performed within the scope of	-CV-
	10. The Co-Occurring I/DD Specialized Capacity CSU must employ, a	eas. employ, at a minimum, one full-time-equivalent (FTE) Registered Behavior Technician (RBT) who is	030
	directly supervised by the BCBA, and who is responsible for the in	directly supervised by the BCBA, and who is responsible for the implementation Applied Behavior Analysis (ABA) aspects of treatment. Functions performed by	088-
	required staffing ratios defined below.		EL
	apacity CSU must	employ other direct care staff who hold credentials such as the Direct Service Professional (DSP) and/or	R
	other health service technician designations.		[
	12. The Co-Occurring I/DD Specialized Capacity CSU must maintain	maintain the minimum following staffing ratio for its Specialized Capacity beds: (as defined abova) on all shifts (note: this is a <i>minimum:</i> a higher number of direct care staff should be	Dod
	used if acuity of individuals served indicates a se	מ מספיני) כון מון כווונס (ווסני: נווס זס מ יוווווווומון) מ וווקונטן וומוווסכן כו מוויכני כמול טנמון טוסמון טכי	cun
	b. 3-4 individuals served = Two (2) direct care staff (as define	3-4 individuals served = Two (2) direct care staff (as defined above) on all shifts (note: this is a minimum; a higher number of direct care staff should be	ner
			nt 4
	c. 5-6 individuals served = 1 finee (3) direct care staff (as definer used if acuity of individuals served indicates a safety need).	5-6 individuals served = I hree (3) direct care staff (as defined above) on all shifts (note: this is a <i>minimum</i> ; a higher number of direct care staff should be used if acuity of individuals served indicates a safety need).	48- ⁻
	1. CSU must have documented operating agreements and referral m	referral mechanisms for osvchiatric disorders, substance use disorders, and physical healthcare needs	73
	-	that are beyond the scope of the CSU and that require inpatient treatment. Operating agreements must delineate the type and level of service to be provided by	
	the private or public inpatient hospital or treatment facility. These a	the private or public inpatient hospital or treatment facility. These agreements must specifically address the criteria and procedures for transferring an individual to	File
		he individual.	ed
	2. CSUs must follow the seclusion and restraint procedures included	CSUs must follow the seclusion and restraint procedures included in the Department's policy: CSU: Use of Seclusion or Restraint in Crisis Stabilization Services,	11/
	3. The following restraint practices are prohibited:		29
	a. The use of chemical restraint for any individual.		/23
Clinical	The combined use of seclusion and mechanical,	and/or manual restraint.	}
Operations			Pa
	d. PKN orders for seciusion or any form of restraint. A Prope manual or mechanical restraints		age
		arried or moved.	2
	_	rt Plan (BSP) or an Individual Recovery Plan (IRP).	30
	h. The use of handcuffs for an individual not under the jurisdiction of the criminal justice system.	tion of the criminal justice system.	of 6
		وتوثيم ميلا لمسيميا لمريسي ومن سوم ونظل مونادا الماموناد الملمو وسيمام بمداد الماموناد الملمو مسيمامي بداد ادمور علاام	52 ⁻
	4. For individuals with co-occurring diagnoses including benavioral nearth and developmental disability related symptoms, behaviors, manifestations, and skills-development related to the identified issue.	For individuals with co-occurring diagnoses including benavioral nearth and developmental disabilities, this service must larget the crisis- related symptoms, behaviors, manifestations, and skills-development related to the identified issue.	7
			_ =·

Crisis Stabilization Unit (CSU) Services - Co-Occurring Intellectual & Developmental Disability (I/DD) Specialized Capacity

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Crisis Stabilization Unit (CSU) Services - Co-Occurring Intellectual & Developmental Disability (I/DD) Specialized Capacity

- Individuals served in transitional beds may access an array of community-based services in preparation for their transition out of the CSU and are expected to engage in community-based services daily while in a transitional bed ς.
 - Medication must be administered by licensed or credentialed* medical personnel under the supervision of a physician or registered nurse in accordance with <u>ن</u>
- Immediately upon admission, the CSU must implement its internal policies and procedures for managing crisis situations, based upon the individual's presenting behaviors and needs.
- Within thirty-six (36) hours of admission, an individualized crisis plan must be developed (or updated, if one already exists) and implemented for each individual served by the CSU's clinical team. ω.
- Any needed behavior intervention component of this plan (i.e., ultimately resulting in a Positive Behavior Support Plan) should be added as soon as possible, but at a minimum, must be added in accordance with the timeframes and criteria listed in the Behavior Intervention Services item below.
- CSU staff involved in the development and implementation of the individualized crisis plan should ensure ongoing consultation with the BCBA during the BCBA's assessment and planning processes to ensure continuity between the Positive Behavior Support Plan and other components of the crisis plan.
- Behavior Intervention Services (only applicable to individuals with either a suspected presenting need for behavior intervention services at the time of admission, or who evidence a need at a later point during their stay): <u>ග</u>
- business days of admission, (or within three (3) business days of evidenced need; if this need was not identified at admission) to develop an individualized As a component of the overarching individualized crisis plan, a BCBA must begin a functional behavior assessment of each individual within three (3) Positive Behavior Support Plan that addresses crisis-related behaviors.
- CSU must use an established adaptive behavior assessment such as the Adaptive Behavior Assessment System, 3rd Ed. (ABAS-3), Vineland Adaptive If clinically indicated, an adaptive behavior assessment can be completed during the initial assessment by the appropriate credentialed provider. The Behavior Scales, 3rd Ed, etc. <u>.</u>
- n accordance with a needs assessment, CSU staff must work to identify any behavioral health and/or I/DD treatments and supports that will be needed postdischarge. When post-discharge behavior intervention services are indicated, the BCBA should assist in identifying and contacting an appropriate outpatient ပ
- implementation, fidelity, and progress monitoring will be informed by quantitative data collected on the individual's behaviors while admitted to the CSU Positive Behavior Support Plans and behavior-change programs will be conceptually consistent with behavior analytic principles. Treatment ö
- Within seven (7) business days of admission (or within seven (7) business days of evidenced need; if this need was not identified at admission), a provisional Positive Behavior Support Plan must be developed (which is focused on the crisis-related behavior) and implemented. ω̈.
 - Within ten (10) business days of admission (or within ten (10) business days of evidenced need; if this need was not identified at admission), a finalized Positive Behavior Support Plan must be fully implemented. ب.
 - Training for natural and formal support persons (only applicable for individuals who receive behavior intervention services) 10.
 - a. The staff of the CSU will provide training for the individual's natural and formal support persons.
- The CSU will make accommodations to ensure that natural/formal support persons are able to participate in training regardless of their proximity in relation to the CSU Þ.
- This training shall, at a minimum, result in the following basic, introductory-level knowledge and competencies:
 - Knowledge regarding the individual's complete diagnoses;
- ii. Knowledge regarding the positive behavior support plan developed on the unit;
- iii. Knowledge and competence regarding how to respond to challenging behaviors;
- iv. Knowledge and competence regarding how to prevent challenging behaviors;
- v. Knowledge and competence regarding how to advocate for the individual's needs; and
- vi. Knowledge and competence regarding how to respond and implement the crisis safety plan.

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Crisis Stabilization Unit (CSU) Services - Co-Occurring Intellectual & Developmental Disability (I/DD) Specialized Capacity

- In the Positive Behavior Support Plan (PBSP) component of the crisis plan:
- A PBSP provides the primary direction for/management of behavior intervention services in the CSU, and must therefore be included as a major and coordinated component of the overarching individualized crisis intervention plan, and can include the following standard elements:
 - Background and Statement of Problem
- Relevant Medical History/Medical Necessity
- Functional Behavioral Assessment
 - Reinforcer Identification
- Baseline Data
- Rationale for Current Plan and Procedures
 - Behavioral Objectives/Behavior Goals
- Alterations to Interactions and the Environment
- Replacement Behavior Teaching & Skill Acquisition Training
 - Reinforcement Procedures 10
- Strategies for Decreasing Inappropriate Behaviors
 - Data Recording/Fidelity Monitoring
 - Seneralization, Maintenance, Fading Strategies 5. 5.
- Staff Training/Caregiver Training
- Program Monitoring 14.
 - **Risks and Benefits** 6.
 - Consent
- Data Collection Forms Challenging, replacement behavior & skill acquisition ∞.
- Monitoring Forms/Fidelity Checklists
 - Staff Training Records/Plan 20.
- For individuals who already have an active Positive Behavior Support Plan that was developed by another service provider, the CSU should use interventions from that existing Plan to inform the development of the interventions to be implemented during the crisis stabilization process. :=
- For individuals needing crisis-related behavior intervention services, the CSU must have detailed documentation of the interventions that were identified in the Positive Behavior Support Plan, and that these were both attempted and exhausted before initiating more restrictive interventions. တ်
- behavior change programs, replacement behaviors, skill acquisition, and medication changes related to behavior intervention and the emanating crisis behaviors. For individuals needing crisis-related behavior intervention services, the CSU must maintain documentation of quantitative data, graphs and narrative analysis of
 - For individuals needing crisis-related behavior intervention services, the CSU must maintain documentation of fidelity monitoring regarding implementation of the Positive Behavior Support Plan and intervention competency training of staff and caregivers. œ.

Forensic	Forensic Peer Mentor - Peer Support	ort												
Transaction Code	Code Detail	Code	Mod 1	Mod 2	Mod Mod Mod 2 4	Mod 4	Rate	Code Detail	Code	Mod 1	Mod 2	Mod Mod Mod Mod 1 2 3 4	Mod 4	2
Peer Support	Practitioner Level 4, In-Clinic H0038	8E00H	关	4N	90			Practitioner Level 4, Out-of-Clinic	H0038	¥	HK 04 U7	U7		
Services	Practitioner Level 5, In-Clinic H0038 HK	H0038	关	U5	Ol6			Practitioner Level 5, Out-of-Clinic	H0038	¥	HK U5 U7	U7		
Unit Value	1 encounter							Utilization Criteria	TBD					

Rate

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Mentors (FPMs) support individuals in preparing for a life free from judicial involvement, and provides ongoing support during and after release from judicial obligations. reduction in the likelihood of recidivism among judicially involved individuals with serious mental illnesses and/or co-occurring substance use disorders. Forensic Peer Forensic Peer Mentor - Peer Support is a service intended to promote recovery and wellness, assist with community re-entry/integration efforts, and support a

Health and Developmental Disabilities (DBHDD). The DBHDD contracts with providers of peer services, which employs Forensic Peer Mentors (FPM) to implement the The service is provided through partnership between participating judicial agencies, contracted providers of peer services, and the Georgia Department of Behavioral

between a FPM and a judicially involved person with a behavioral health condition to resolve current, and prevent future involvement in the judicial system. In addition development of natural supports among individuals involved in the judicial system. The goal of the service is to foster a positive and intentionally mutual relationship FPMs who deliver the service provide interventions that promote recovery, wellness, independence, self-advocacy, recidivism reduction strategies, and the the FPM assists individuals in regaining control over their own lives and recovery.

FPMs initiate and maintain relationships with associated judicial system agencies and team members to support peers in communicating progress, concerns, and any challenges or barriers to meeting judicial system requirements and expectations. FPMs attend facility/community trainings and staff meetings, as agreed to through collaboration with judicial agencies, and as outlined in MOU/MOA developed between judicial agency and provider of peer services.

building hope and recovery capital, and tapping into individuals' strengths), the FPM assists individuals in galvanizing the recovery process. FPMs utilize their unique The FPM initiates the service by using a person-centered engagement of peers who are currently involved in, or at increased risk of returning to, the judicial system. Through the use of their own recovery skills, and by initiating recovery dialogues (for example, sharing their own recovery story, exploring possibilities for recovery, lived experience to model the recovery journey; assist their peers in recognizing, understanding, and relating their own recovery stories; support their peers in the development of their own recovery goals and self-directed recovery processes; and promote a successful life of meaning and purpose in the community of each ndividual's choice.

In order to accomplish the goals of the service, the following trauma-informed, and culturally-competent recovery principles, self-help strategies, and self-advocacy supports are utilized:

Exploring the need for:

Definition Service

- Transitional supports/resources (housing, employment, financial, medical, mental health, transportation, food, clothing, state ID or driver's license, childcare, benefits, etc.);
 - Development of personal goals and articulating them;
- Discovery of personal strengths and utilizing them to achieve goals;
- Identification of potential outcomes, opportunities, and challenges/barriers in accomplishing goals; ö
- Linkage to mutual self-help support groups and recovery-related social events, and encouraging participation;
- Recognition of fears (i.e. in preparation for community re-entry, repairing relationships, living in recovery) and strategies for overcoming them;
- Changes in thinking patterns and behaviors that put the individual at risk for further justice system involvement/recidivism; and 9.4.9.5
 - Exploration of individual, cultural, and faith-based connections, beliefs, and values.
- Development, supporting, and/or modeling of:
- Problem-solving and healthy coping techniques; ä
 - Career/education motivation and related skills; <u>.</u>
- Establishing and/or maintaining healthy, natural support systems in community and with family (biological or identified); ပ
 - If desired, the creation and ongoing maintenance of a personal Wellness Recovery Action Plan (WRAP);

	 e. If desired, the creation and ongoing maintenance of a Whole Health Action Management Plan (WHAM); f. Plans for community resource linking, acquisition, and transportation to judicial requirements, community mental health, medical services, entitlement agencies, and other identified resources needed to encourage empowerment; g. System and community navigation and self-management; h. Skills in reporting to judicial agencies (probation/parole officials, judges, etc.); i. Recovery, activism, and advocacy aimed at reducing stigma. j. Appropriate inclusion of individual's personal, cultural, and faith-based beliefs in recovery plan; and 	Case
Admission Criteria	FPM services are targeted to adults who meet the following criteria: 1. Individual is living with a behavioral condition(s). 2. Individual needs assistance in developing natural supports systems that are actively engaged in encouraging wellness, empowerment, and self-advocacy; 3. Individual wants to receive the FPM service provided by a FPM; 4. Individual may or may not currently be receiving forensic services.	1:16-cv-0308
Continuing Stay Criteria	1. Individual continues to meet admission criteria; and 2. Weekly activity notes document progress relative to the individual's treatment/recovery goals, but these goals have not yet been achieved.	88-EL
Discharge Criteria	 An adequate continuing recovery plan has been established; and one or more of the following: Goals and/or objectives related to FPM services have been substantially met; or Individual requests discharge; or Transfer to another service/level is more clinically appropriate. 	R Docu
Service Exclusions	None	ımen
Clinical Exclusions	 Individuals diagnosed with a Substance-Related Disorder and no other concurrent mental illness; or Individuals with the following conditions are excluded from admission unless there is clearly documented evidence of a co-occurring behavioral health condition: developmental disability, autism, neurocognitive disorder, or traumatic brain injury. 	t 448-73
Required	 FPM services are primarily provided in 1:1 CPS-F to person-served ratio and may additionally include FPM facilitated rehabilitative groups. Services should be person-centered and driven by the individual. Partnered-peer list ratio should be no more than 1:20. Partnered-peer list ratio should be no more than 1:20. Peer Supports cannot operate in isolation from the rest of the programs within the facility or affiliated organization. The FPM shall be empowered to convene multidisciplinary team meetings regarding a participating individual's needs and desires, and the Forensic Peer Mentor must be allowed to participate as an equal practitioner partner with all staff in multidisciplinary team meetings. They also have the unique role as an advocate to the individual served, encouraging them to steer goals and objectives in Individualized Recovery Planning. Contact must be made with the individual receiving FPM services a minimum of twice each month. At least one of these contacts must be face-to-face or telephone contact depending on the individual's support needs and documented preferences. 	B Filed 11/29/23
Staffing Requirements	 The providing practitioner is a Georgia-Certified Peer Specialist (CPS-MH or -AD), and has obtained additional certification as a Forensic Peer Mentor. In addition, the following must be met: The practitioner must have, at time of hire, certification as a Georgia-Certified Peer Specialist (CPS-MH or –AD and At the discretion of the hiring provider, qualified CPS practitioners without the FPM-specific certification can be hired upon the condition of obtaining this certification within six (6) months of hire. 	Page 235 o
Clinical Operations	The providing practitioner delivers all FPM services under the auspices and supervision of the contracted provider of peer support services.	f 627

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	Some data by provided in a carry particle.
Documentation 1. FPMs Requirements 2. Weel	 FPMs must comply with all data collection expectations in support of the program's implementation and evaluation strategy. Weekly activity notes, and a Monthly programmatic report.
Billing and 1. For the Reporting 2. For the Requirements	 For this service, the U6 In-Clinic modifier is utilized when the service occurs in a DBHDD facility, CSU, prison, jail, or other institutional setting. For this service, the U7 Out-of-Clinic modifier is utilized when the service occurs outside a facility or institution as referenced above.

Georgia Hou	Georgia Housing Voucher Program	odram												
Transaction Code	Code Detail	Code	Mod 1	Mod 2	Mod 3	Mod 4	Rate	Code Detail	Code	Mod M	Mod Mod 2	Mod 4	Rate	
Supported Housing		H0044	RR				Actual cost							
Unit Value	Rental Cost							Maximum Daily Units	Ļ					
	The Georgia Housing Voucher Program (GHVP) ass immediate access to a housing subsidy. Supportive services that are available to support individuals' betrecovery, active engagement, and person centeredn is tenant-based, which allows individuals to choose a participation in the GHVP will require engagement w	Voucher Proc thousing sub able to suppo gement, and p allows individed.	gram (GF) saidy. Sul ort individuals to ceduals to ceedaage	HVP) ass pportive uals' beh threredne shoose a sment wi	ists indiv Housing lavioral h ess. The in apartm	iduals in includes includes ealth ne GHVP s	attaining safe is integrated, pereds and promo supports information based on the promote the inc	The Georgia Housing Voucher Program (GHVP) assists individuals in attaining safe and affordable housing. The GHVP supports community integration by providing immediate access to a housing subsidy. Supportive Housing includes integrated, permanent housing with tenancy rights, linked with flexible community-based services that are available to support individuals' behavioral health needs and promote stability in the community. The GHVP promotes housing as a foundation of recovery, active engagement, and person centeredness. The GHVP supports informed choice and is based on personal housing needs and preferences. The voucher is tenant-based, which allows individuals to choose an apartment location based on their needs. The program design does not mandate clinical services, however, participation in the GHVP will require engagement with supports that promote the individual's health, safety, and maintenance of housing stability.	P supporhts, linked GHVP propertions and housing does not renance o	ts commod with flex comotes I comote como mandate of housing	unity integ xible comr housing as and prefe clinical se g stability.	gration by munity-bases a foundarences. Therees, ho	oroviding sed tion of ne voucher wever,	
Service Definition	The program consists of: 1. The service participant; 2. Community-based service providers who provide one or more of the following:	of: ipant; I service prov	iders wh	o provide	e one or	more of	the following:							
	a. "Wellness" case manag b. "Wellness" case manag c. Housing supports (e.g., with landlord communic 3. The landlord/property owner.	"Wellness" case management intervention "Wellness" case management intervention Housing supports (e.g., assistance with landlord communications, assistance andlord/property owner.	ment inte assistance tions, ass	ervention e with co sistance	is specifii impleting with mov	c to GHV GHVP r	is specific to GHVP participants ompleting GHVP application/pap with move-in process, providing	"Wellness" case management interventions specific to GHVP participants "Wellness" case management interventions specific to GHVP participants Housing supports (e.g., assistance with completing GHVP application/paperwork, identifying potential housing options, assistance with move-in process, providing support for housing stability needs, etc.); and indlord/property owner.	ng option ls, etc.); a	is, assisti and	ng with ho	ousing pro	cess, help	
Admission	DBHDD will solicit pote population of homeles: status, eligibility, avails history of employment, reserves the right to pr	ential candide s individuals of ability of other criminal back	ates for the with men rhousing skground, riget population	ne GHVF tal illnes; placeme and dail	from DE ses. All in ents or p iy living s	SHDD st ndividua rograms kill anal	ate hospitals, c is who meet the income, the n, income, All selectic ysis. All selectic	DBHDD will solicit potential candidates for the GHVP from DBHDD state hospitals, crisis settings (e.g. BHCCs, CSUs, etc.), jails, prisons, hospital ERs, and the population of homeless individuals with mental illnesses. All individuals who meet the admission criteria are eligible. Selection will be based on current residential status, eligibility, availability of other housing placements or programs, income, the need for support services and the desired location's support service capacity, history of employment, criminal background, and daily living skill analysis. All selections are at the sole and absolute discretion of the DBHDD, and the DBHDD reserves the right to prioritize the target population based on need, budget considerations, or any other criteria established by DBHDD.	etc.), jails election w desired lo iscretion of	s, prisons vill be bas cation's sorthe DE of the DE DBHDD.	s, hospital sed on cui support se 3HDD, and	l ERs, and rrent resid ervice cap; d the DBH	the ential acity, DD	
Criteria	 Criteria: a. The individual must be at least 18 years of age; b. The individual must have a psychiatric diagnosis Behavioral Health and Developmental Disabilitis months (individuals with a co-occurring SUD diagnosis) 	ual must be at lal must have Health and De ividuals with a	t least 18 a psychi evelopme a co-occu	years of iatric diac	fage; gnosis th <u>abilities' I</u> ID diagno	at qualif Definitio osis or d	ies as a Seriou. n of Severe and evelopmental c	ia: The individual must be at least 18 years of age; The individual must be at least 18 years of age; The individual must have a psychiatric diagnosis that qualifies as a Serious and Persistent Mental Illness (SPMI), as defined in Georgia Department of Behavioral Health and Developmental Disabilities' Definition of Severe and Persistent Mental Illness, 01-121, and that has been verified in the past 12 months (individuals with a co-occurring SUD diagnosis or developmental disability are also eligible); and	PMI), as (1, and tha	defined in	n <u>Georgia</u> en verifiec	Department in the partment in	int of st 12	

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Georgia Housing Voucher Program

- Determination of the Unit Size for the Household Composition The GHVP has established subsidy standards that determine the number of bedrooms needed for the household size and composition: Si
- The GHVP will use the following chart in determining the appropriate voucher for a household:

Voucher Size	Persons in Household (Minimum – Maximum)
1 Bedroom	1-2
2 Bedrooms	2-4
3 Bedrooms	3-6
4 Bedrooms	4-8
5 Bedrooms	6-10

- The GHVP does not determine who within a household will share a bedroom/sleeping room.
 - The following requirements apply when determining the size of the unit:
- The subsidy standards must provide for the smallest number of bedrooms needed to house the intended occupants without overcrowding (see table
- The subsidy standards must be consistent with space requirements under the housing quality standard;
- The subsidy standards must be applied consistently for all households of like size and composition;
- Any live-in aide (must be if-approved by GHVP for medical reasons) must be counted in determining the household unit size; نه ن
- A household size consisting of a single individual must be either a zero-bedroom (i.e., a studio or efficiency unit) or one-bedroom unit... At the DBHDD's full and absolute discretion, approval may be granted for a two-bedroom unit that meets all requirements of the GHVP and that has a rental value less than or equal to the Maximum Rent, if there is a verified lack of one-bedroom rental unit inventory within the individual's desired county of residence.
 - For households with more than one Head of Household (HOH), GHVP will assign separate bedrooms to individuals in the household under the following
- A single/unmarried head of household will be assigned a separate bedroom (married spouses will share a bedroom) from any other adults or children who are officially approved to reside in the home and who are included in the household size determination (including live-in aides);
- Two or more children (under age 18) of the same gender will be assigned a shared bedroom, which is separate from the head of household's bedroom;
- In determining household size, the GHVP may grant an exception to its established subsidy standards if the GHVP determines that the exception is justified Two or more children (under age 18) of different genders will be assigned separate bedrooms from one another, and which are separate from the head of household's bedroom.
 - by the age, gender, health, handicap, relationship of family members, or other personal circumstances. Reasons may include but not limited to: တ်
 - A need for an additional bedroom for medical equipment;
- appropriate documentation. Requests based on health-related needs must be accompanied by verification from a licensed professional (e.g., doctor or other health professional). The household's continued need for an additional bedroom due to special medical needs must be re-verified at annual exception to the subsidy standards must be in writing. The request must explain the need for justification for a larger family unit, and must include A need for a separate bedroom for reasons related to a family members disability, medical, or health condition. The household's request for an eexamination.

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Georgia Housing Voucher Program

- In the interest of child welfare, households that include minors (anyone under 18 years of age) must provide legal documentation providing proof of the barental/familiar relationship prior to lease approval by the Regional Field Office, without exception.
- 3. Income and Rent Determination
- a. Tenant Contribution
- For initial leases, all individuals with financial means will be required to contribute 30% of their income toward their living expenses (tenant paid utilities, rent, and initial start-up expenses).
- If an individual has no income at the time of program entry, the individual must locate a unit that includes utilities.
- For initial/new leases, households may not pay more than thirty-five percent (35%) of their household income toward rent and utilities.
- In no case, without prior DBHDD approval, will DBHDD allow the individual to pay more than 40% of their income toward rent and utilities.
 - At lease renewal, individuals may pay as much as 40% of their income toward rent and utilities.
- The individual is expected to use their own financial resources (e.g. referral to SOAR and/or Supported Employment) to meet the needs of any subsequent costs associated with utilities. Neither the GHVP nor the Bridge program provides financial support for on-going utility assistance. Þ.
 - c. Rent Determination
- If approved for the GHVP, calculations to determine the tenant's portion of the rent will include any additional tenants' income.
- GHVP-5, Rent Determination Payment Standard Income Certification form must be used as part of the initial submission package.
 - iii. All household income must be included.
- All adult non-student and non-related members must contribute their pro-rated share of the rent before calculations are made for the GHVP covered individual
- d. Change in Tenant Income During the Lease Term
- When a GHVP-4 (Tenant Information Form) is submitted to notify of a change in payment due to an increase/decrease in income on behalf of the individual during the lease term, supporting income documentation must be submitted with the packet.
- If the individual reports that they are no longer working or receiving income, a separation letter from the employer, statement from the payor source, etc. must be submitted as verification with the packet. ≔
 - If the individual reports an increase or decrease in income, at least one of the following is required and must be submitted for verification: ≔
- Check stubs,
- 2) Letter from the employer,
- 3) Letter from the Social Security Administration,
 - Statement from the payor source.
- Effective Date of Payment Change: When an individual's income changes (increases or decreases) during the lease term, the effective date of the change will be the first day of the following month, not during the same month of the income change. .≥
- 4. Service Provider Roles, Responsibilities and Conditions of Participation in the GHVP
- will minimally provide each GHVP participant a basic level of case management for program compliance, health, safety, and wellness. All individuals newly Provision of Services: As of December 1, 2018, Service Providers who refer and provide supportive services to individuals who meet criteria for the GHVP enrolling, and eurrently enrolled in the GVHP are expected to engage in support services that promote community integration, coordination of desired services, and housing stability.
 - support service needs, the Current Provider responsible for placing the individual into the community, and the support service provider responsible Each prospective tenant must have an Individualized Recovery Plan that documents the tenant's desire to live independently, the individual's for on-going supports matched to their needs.
 - ii. All individuals enrolled in the GHVP shall receive support for the following:
- Screening and housing assessment for an individual's preferences and barriers;

Bridge Funding

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Developing an individual housing support plan: Identifying goals, addressing barriers, establishing approaches to meet their goals, including

identifying available services/resources;

Georgia Housing Voucher Program

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Georgia Housing Voucher Program

- Bridge Service Providers must utilize the GHVP-3 Bridge Funding Request Form and all expenses must be supported with receipts as required in Bridge Funding may be utilized to repair any damages inflicted upon the housing for which the household is deemed responsible.
- Bridge Funding Payments for Federal Housing Assistance Programs ω̈.

the normal claims process.

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- Bridge Funding will be permitted for individuals who are approved and determined eligible through the Unified Referral Process (URP) for federal housing assistance programs.
- For new individuals, a one-time initial move in expense is approved (as listed on the GHVP-3 Bridge Funding Request- HUD Federal Assistance Programs Only Form). \$3,000 is approved for new applicants (Up to \$2,500 for eligible expenses and \$500 provider fee).
 - Total Bridge Funding requests exceeding \$3,000 must receive DBHDD approval before expending money on the tenant's behalf and must be supported with proposed estimates.
- For GHVP Transfers to a federal housing assistance program, a one-time initial move in expense is approved (as listed on the GHVP-3 Bridge Funding Request- HUD Federal Assistance Programs Only Form). The Provider will receive a \$500.00 fee for completing the GHVP Transfer. တ်
 - Bridge funding on a case-by-case basis may be (at the discretion of DBHDD) used for the following: _
 - Abatement of bed bugs
- Economic hardship for a utility payment
- Moving expense when the landlord/property owner no longer accepts the GHVP and the tenant must move due to no fault of their own.
- Landlords/Property Owners and the Apartment Unit 9
- In no case will the rent paid to landlords/property owners exceed rent for a comparable non-GHVP assisted unit in the same complex. ъ. Б
 - In order for a landlord/property owner to participate and to receive payments, the landlord/property owner must agree to:
- Participate in direct deposit (EFT) payments through PaySpan. Landlords/property owners may sign up by contacting PaySpan customer service at 1-877-331-7154.
- Allow an Annual Housing Quality (HQS) Inspection of any unit for which the landlord/property owner is receiving payment.
 - Provide IRS Form W-9 and one of the following IRS documents:
- 1) IRS Form 147C or IRS Form CP575A as verification of Tax ID number, or the submission of a Social Security Card for the landlord/property owner, before a rental payment can be paid or a lease is signed under the GHVP.
- The tenant is fully responsible for all damages done to the unit.
- DBHDD will renew an individual's enrollment in the GHVP at its sole and absolute discretion. DBHDD is under no obligation to approve an automatic ease renewal. ن خ
- GHVP Transfers, Portability, Disbarment, and Reapplication 7
- The GHVP is portable. A transfer must adhere to the following:
- Individual must submit a written request to the Service Provider at least 90-days before the end of the current lease;
- The regional office will complete the Transfer Request Form and ensure the following:
- Individual cannot be in arrears on rent and/or utilities;
- ndividual must have clearance from the appropriate authority if individual is involved in any open investigations from a government agency and/or criminal proceedings (e.g., open child protection case, currently on probation/parole, current pending charges);
- Individual must have the ability to cover moving expenses (GHVP is not financially responsible and Bridge does not cover these expenses);
 - Individual must have a minimum of six months of financial stability, with steady income and ability to manage household budget and

expenses; and

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m rd}$ Quarter Provider Manual for Community Behavioral Health Providers (January 1, 2023)

Payment Termination

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DBHDD may at its sole and absolute discretion, disbar any individual from future participation in the GHVP if the household violates any of the

Individual must be in compliance with their current lease.

Program Disbarment

Georgia Housing Voucher Program

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 a. Master Leasing Agreements (MLAs) can help create additional housing options for individuals with multiple housing barriers. GHVP allows MLAs in which there is a master lease contract between a Service Provider and a Landlord/Property Owner in order to lease apartment units under the name of the Service Providers that wish to individuals in the GHVP. i. Service Providers that wish to offer MLAs do not require a separate agreement with DBHDD and must adhere to the following requirements: j. The sub-lease must be in the individual's name. 2) The individual must maintain all tenancy rights. 3) The tenant must maintain all tenancy rights. 3) The tenant must maintain their right to privacy. 4) The rental rate of the sublet unit charged to the tenant may not exceed the market rate of the unit as paid by the Service Provider. 5) No more than 20% of the units in a single building with at least 5 units may be GHVP-funded. 6) The tenant remains responsible for the cost of vacant units or any administrative costs associated with master leased units. b. In order to ensure a GHVP recipient has the benefit of consumer housing choice, the Service Provider must also identify at least two additional housing options that are not part of an MLA involving the same Service Provider. c. Service Providers must provide DBHDD with the lease document executed agreement between the Service Provider and the landlord/property owner. 	 10. Fidelity Monitoring and Program Evaluation a. Service Providers will participate as requested and deemed appropriate by DBHDD in annual Fidelity Monitoring process. b. Service Providers shall provide DBHDD with all requested information regarding the agency's participation in the GHVP in order to conduct an assessment of the Service Providers' operation and provision of services as it relates to GHVP and supportive housing services. c. Service Providers will receive training on this process from DBHDD as well as technical assistance to support the success of Service Providers. 	 GHVP Forms and Descriptions Current Service Providers must use the GHVP forms provided by the DBHDD's Office of Supported Housing. Any outdated forms may not be accepted and may result in the loss of all or part of the provider fee. b. For individuals being newly referred to the GHVP, in order for the Regional Field Office to determine program eligibility, the forms below should be completed by the Social Body and NSU Determined. 	in Submitted by the Service Frontier via the No. i. Individualized Treatment / Recovery F. to live independently, the individual's sur support service provider responsible for ii. GHVP-14: Declaration of Citizenship S. with the initial referral. This form is required.	iii. GHVP-20: Release of Information/Consent Form. This form must be completed by the applicant in order to allow the release of the information they have provided to the Service Provider to DBHDD. iv. GHVP-21: Wellness Case Management Acknowledgement Form. This form must be signed by the individual in acknowledgement of the requirement to receive wellness case management while in the GHVP program. v. GHVP-22: Certification of Homelessness (if applicable). This form is only required if the individual is reporting a history of chronic homelessness to be deemed eligible. It requires documenting episodes of homelessness over time.
			Documentation Requirements	

Georgia Housing Voucher Program

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 Georgia Housing Vouclate Program in GHPP-23. Zace-income Form (if busehold has no income). This form is required for includuals being referred who report having zoo income in individuals without income are still eighble for CHPP and are likely to experience additional housing bearines. All zao income individuals without income are still eighble for CHPP and are likely to experience additional housing bearines. All zao income individuals without income are still eighble for CHPP and are likely to experience additional housing services because of Severe and Proceed issend to the current Services Proceeding representability. We finded the completed and summitted by the Service Provider: c. For individuals may be removed to assist the individual in their search for affordate housing that in the search of the current Services Provider in gestate the AIPP. Services Provider to assist the methy (123) days from that Services and services and their operation of their search of their search of their search of a services and requirements. The CHPP are serviced services and other providual in their search for a service and services and other programs requirements. The CHPP are serviced services and other programs requirements. The services and other programs requirements. The services of their services and other programs requirements. The services of their services and other programs requirements. The services of their services are serviced services programs and services are an other services. ii. GHPP-2. Seride Funding Required Like and the individuals are recovered to the Stope and the services and other programs requirements. The services in the services are serviced services and other programs requirements. The services in the services are serviced services and other services and other services. The services in the services are serviced services and services are serviced services. The services in the services are serviced services and services are serviced services. T		Case	1:16-cv	-03088-	ELR	Docun	nent 448	3-73	Filed 11	/29/23	Page	244	of 627
vi. vii. vii. vii. vii. vii. vii. viii. viii.	Program GHVP-23: Zero-Income Form (if household has no income). This form is required for individuals being referred who report having zero income. Individuals without income are still eligible for GHVP and are likely to experience additional housing barriers. All zero income individuals should be referred to the SOAD program.	GHVP-24: Disability Verification Form. The Disability Verification form must be completed for all applicants by a licensed practitioner to document a diagnosis of Severe and Persistent Mental Illness (SPMI) in order to be eligible for GHVP. viduals newly enrolling in the GHVP, the forms below should be completed and submitted by the Service Provider:	GHVP 1: The Notice to Proceed issued to the current Service Provider represents DBHDD's approval of the referral application and authorizes the current Service Provider to assist the individual in their search for affordable housing that meets GHVP standards and requirements. The GHVP-1 is active for one-hundred and twenty (120) days from the notice's date of issuance. After 120 days, the authorization for a voucher will no longer be	valid unless the Keglonal Field Office has received evidence of ongoing housing search efforts from the supporting provider agency and approved an extension. DBHDD and its Regional Field Offices have sole discretion regarding the extension of a GHVP Notice to Proceed. GHVP-2: Lease Addendum is a required form that details DBHDD's responsibilities, the amount that the tenant owes toward rent, the breakout of utilities, unit quality standards and other program requirements. The form must be signed by the owner and the tenant.	GHVP-3: Bridge Funding Request . The Bridge Funding Request must be submitted by a Service Provider when submitting claims for eligible expenses made on behalf of individuals serves under the Bridge Funding service. Only those items on the checklist may be purchased with Bridge Funding. Any item not on the list must receive pre-approval by the DBHDD's Regional Transition Coordinator.	GHVP-4: Tenant Information . DBHDD will use the information on this form to establish ongoing payments to the property owner, and the amounts to be split between DBHDD and the tenant. Information on this form must be consistent with the same information on GHVP-2, GHVP-5, and W-9. The document must be signed by the current Service Provider and the tenant.	GHVP-5: Rent Determination-Payment Standard Income Determination. This form automatically calculates the tenant's share of rent and utilities and the amount provided by GHVP. If any program requirement appears stating that the rent standard is greater than program requirements or that the individual is paying more than 40% of their income on rent and utilities, the submission package will not be accepted unless prior approval by the	Regional Field Office. Handwritten submissions will not be accepted. GHVP Payment Standards seek to reflect Fair Market Kents (FMKs) as determined by HUD and adapted by the Georgia Department of Community Affairs (DCA) in their administration of the Housing Choice Voucher program. DBHDD also utilizes HUD Small Area FMRs (SAFMRs) for the counties for which DCA does not issue a standard. Standards may also be	adapted to reflect those of local Public Housing Authorities. GHVP-6: Accessibility Modifications. Accessibility Modifications made to the housing unit in order to accommodate the physical needs of the tenant is an eligible Bridge Funding expense. All accessibility modifications must first receive DBHDD prior approval before entering into a lease or authorizing or commencing any work. In submitting the request, the current Service Provider must use GHVP-6; attach a description of the scope of	work, Property Owner approval of the work scope, and estimates by a licensed contractor. Every effort should be used by the current Service Provider to locate units using http://www.georgiahousingsearch.org/ that are already adapted to the tenant's needs. All Accessibility Modifications must receive prior documented approval using the GHVP-6, Accessibility Modifications form, even if it is the initial Bridge Funding Request and the	GHVP-7: Notice of Change in Payment/Owner. At any time when rent changes or property owner information changes this form should be used to document those changes. This form must be used when the lease is renewed even if no changes are made in either rent or property owner.	Additional property contact information will assist future communication with the property owners. GHVP-8: Notice of Lease Cancellation. The Notice of Lease Cancellation is used to terminate GHVP subsidy payments on behalf of a tenanticular served. If any current Service Provider knows that any GHVP tenant is no longer living at a contracted unit, the current Service.	Provider must submit the Notice of Lease Cancellation form. If known, the reason for the cancellation should be provided. GHVP-10: Determining Your Housing Needs. Current Service Providers are required to document, using GHVP-10 Determining Your Housing Needs, that they inquired about the desires of the individual concerning their living preference, the characteristics of the rental community, the
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design of the specific unit. All new placements must submit a GHVP-10. Current Service Provider is required to use GHVP-10, Determining Your Housing Needs, when discussing the tenant's potential housing options.

- one or more may be required by the landlord/property owner in order execute the lease agreement, or by the GHVP in order to determine household size. Moreover, it is the expectation that if any of the following documents is not already within the individual's possession, the service provider and Program). A signed GHVP-11 will be required at lease signing. Although not all of the documents below are required by the GHVP at lease signing, GHVP-11: Documents and Compliance with GHVP Requirements. To ensure that the individual will have access to other forms of housing supports, the GHVP program will align its requirements with other mainstream programs (e.g., Shelter Plus Care of Housing Choice Voucher individual will work to obtain them within 3 months:
 - Photocopy of the social security card for each household member or a letter from the Immigration and Naturalization Service indicating the social security numbers that have been assigned. SSN Verification letters will also be accepted
 - Photocopy of the birth certificate for each household member.
- Photocopy of picture identification for the head of household.
- 4) Copies of Disability, SSI, or Social Security award letters received by any household member.
- GHVP-12: Mutual Termination of Lease. Although not a required GHVP form, there may be instances when the tenant and the owner, by mutual consent desire to terminate the lease. This form may be used to document that understanding. .<u>×</u>
 - responsible for informing the Regional Field Office within 5 business days that they are no longer providing services. This may occur as a result of instances, where there has been a change in a Service Provider, the GHVP-13: Notice of Change in Provider must be submitted to the DBHDD he individual no longer accepting services from the current Service Provider or there has been a change to another service provider. In those GHVP-13: Notice of Change in Provider. At any time after the individual occupies a GHVP supported unit, the current Service Provider is Regional Field Office. :≓
 - xiii. GHVP-14: Declaration of Citizenship Status.
- owner that a GHVP is missing or was not received on time. This form should be used and forwarded to the Regional Office if coming from the field to GHVP-15: Lease Payment Inquiry. The current Service Provider or the Regional Office may receive communication from the landlord/property document a need to investigate the missing payment. .<u>≥</u>.
 - asked to solicit the impressions of the individual on their experience with the GHVP and Bridge Funding Programs. If the individual consents, the GHVP-16: Tenant Impressions. At initial lease and any subsequent renewals of a GHVP supported apartment, the current Service Provider is current Service Provider should include GHVP-16 with the other submitted documents to the Regional Field Office. ⋛
- additional bedroom to accommodate a live-in aide. In those instances, the individual must forward to DBHDD a completed Certification of Need by a GHVP-17: Certification of Need for Live-In Aide. A GHVP recipient may at initial lease or at any time when circumstances warrant requests an icensed professional for a medical condition that indicates a direct and verifiable need for an extra bedroom and/or live-in aide. ž
 - GHVP-18-a: HQS Form 52580-a: The Service Provider must submit the HQS Form 52580-a indicating successful passage of the HQS inspection for the housing unit. :<u>≓</u>
- GHVP-18: HQS Inspection Results (Repairs only). This form must be completed if a Housing Quality Standards inspection fails and the property requires repairs. In those instances, GHVP-18 should be used to document the repairs, the person responsible for making those repairs, the time frame to complete the work, and when a follow-up inspection will be conducted. .∭ X
 - GHVP-19: Acknowledgement of Tenant Responsibilities. This is a required form to be reviewed with the individual by the Service Provider, completed and signed at initial placement and all subsequent renewals. .<u>≍</u>
- All Current Providers are required to use the Submission Checklist (New Leases, Renewals, Terminations, Changes in Payments) and Cover Memo when submitting documents to DBHDD for GHVP payments. Service Providers should use the most current version of the GHVP Checklist. ۲,

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IRS Form 147C or IRS Form CP575A (Required for landlords/property owners that are assigned an Employee Identification Number) or Copy of Social Verification of income for all family members (wages- 2 most current pay stubs or letter from employer, TANF, child support, SSI/SSA, VA benefits, Security Card (Required for private landlords/property owners). Documents are required for new landlords/property owners only The following documents are not required prior to move-in by the GHVP but are required to be collected within 3 months: GHVP-18-a: HQS Form 52580-a, and GHVP-18: HQS Inspection Results (if repairs are required) GHVP-23: Zero Income Form (required for households with zero income only) GHVP-23: Zero Income Form (required for households with zero income only) GHVP 5: Rent Determination Payment Standard-Income Certification Form GHVP 5: Rent Determination Payment Standard-Income Certification Form Social Security Card or SSN Verification Letters for all household members GHVP-18-a: HQS Form 52580-a, and GHVP-18 (if repairs are required) Pensions, Statement of financial contribution from family or friends) GHVP-11: Documents and Compliance with GHVP Requirements GHVP 19: Acknowledgement of Tenant Responsibilities Form GHVP 19: Acknowledgement of Tenant Responsibilities Form -ease signed by the tenant and the landlord/property owner GHVP 8: Notice of Lease Cancellation (if applicable) GHVP 14: Declaration of Citizenship Status Form GHVP-20: Release of Information/Consent Form GHVP-20: Release of Information/Consent Form IRS W-9 Form for the Landlord/Property Owner RS W-9 Form for the Landlord/Property Owner GHVP-21: Wellness Case Management Form GHVP 16: Tenant Impressions Form (optional) GHVP-21: Wellness Case Management Form Birth Certificate for all household members GHVP 3: Bridge Funding Request Form GHVP 3: Bridge Funding Request Form GHVP 16: Tenant Impressions Form GHVP 4: Tenant Information Form GHVP 4: Tenant Information Form GHVP 1: Notice to Proceed Form GHVP 2: Lease Addendum Form Picture ID for Head of Household GHVP 2: Lease Addendum Renewal Submission Checklist:

New Submission Checklist:

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nat are assigned an Employee Identification Number) or Copy of Social or letter from employer, TANF, child support, SSI/SSA, VA benefits,	Service Providers may bill in accordance with the Service Guidelines as defined in the Behavioral Health Provider Manual for the service in which a GHVP individual is enrolled. Bridge Funding Reimbursement a. Submitting Claims: i. Providers should access the ASO ProviderConnect Portal to submit all bridge claims reimbursements. ii. Providers should utilize the Bridge Funding Service Claims Submission Quick Reference Guide as a resource for entering claims reimbursements.	ProviderConnect can be accessed by using this link: https://www.valueoptions.com/pc/eProvider/providerLogin.do?client=GACO. 1) A User ID and Password is required and must be created by the agency's Super User. equirements Bridge reimbursement requests can only be submitted once there is a signed lease. Claims submitted must be in accordance with an approved GHVP-3 form for audit and reconciliation purposes. All claims must be submitted through the ProviderConnect direct claims entry process and cannot be submitted via batch because of the receipt equirement.	and amount paid. sufficient on agency letterhead or	Claims are paid on a weekly basis. The Provider has the option to receive payments via ACH or paper check. All claims submitted and adjudicated by Beacon's claims staff will be paid with Each Tuesday's check run. Any claims that have been paid and later it was identified that the expense was outside of the guidelines will require the claim to be reversed and payment recouped. Any claims that have been paid and later it was identified that the expense was outside of the guidelines will require the claim to be reversed and payment recouped. Any claims that have been paid and later it was identified that the expense was outside of the guidelines will require the claim to be reversed and payment recouped.
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CP575A crivate lar rivate lar amily me sial control dy on fill old verification old merrold me	nce with street street AS	s access ssword is equests be in acc	a valid st paid to th ncy namon re not ar he claim ill review	serly bas d adjudic sen paid Code
 Georgia Housing Voucher Program IRS Form 147C or IRS Form CP575A (Required for landlords/property owners that Security Card (Required for private landlords/property owners). Lease signed by the tenant and the landlords/property owners. Verification of income for all family members (wages- 2 most current pay stubs or Pensions, Statement of financial contribution from family or friends). If the following documents are already on file, they are not required again for renewal: Picture ID for Head of Household Social Security Card or SSN Verification Letters for all household members Birth Certificate for all household members 	Service Providers may bill in accordan individual is enrolled. Bridge Funding Reimbursement a. Submitting Claims: i. Providers should access ii. Providers should utilize	Claim C	Receipts Receipts must be from a valid store, vendor, or busine I. Receipt is for fees paid to the Provider (e.g., Initia other form with the agency name. III. If items on the receipt are not an approved reimbursab iv. Ensure the amount on the claim matches the amount to the claim matches the amount to Payments	i. Claims are paid on a weekly basis. The ii. All claims submitted and adjudicated by iii. Any claims that have been paid and late payment recouped. High Utilizer Management Code Detail Code Mod
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High Utilizer	High Utilizer Management	
High Utilizer Management	T1016 HW	
	The High Utilization Management (HUM) program provides support to individuals who experience challenges and barriers in accessing and remaining enrolled in desired community-based services and supports. Using a data-driven process, the HUM program identifies and provides assertive linkage, referral, and short-term care coordination for individuals with behavioral health challenges who have a demonstrated history of high crisis service utilization. The program offers support, education,	Case
	and navigation to assist at-risk individuals who could benefit from the removal of barriers to accessing community-based treatment. Utilizing a recovery-oriented approach, HUM services offer care coordination in identifying and gaining access to required services and supports, as well as medical, social, educational, developmental, and other services and supports, regardless of the funding source for the services to which access is sought. The HUM program includes assertive engagement and time-limited follow up to individuals to support and encourage a consistent and ongoing connection with appropriate community resources. Objectives for the programs are to:	1:16-cv-030
Service	 a. Determine the factors related to an individual's high utilization of crisis services (e.g., homelessness, inadequate discharge planning, engagement challenges, cultural factors, etc.). b. Use case management to educate, connect to services, and advocate for the individual.)88-ELR
Definition		Documen
	This service supports effective engagement as defined by one or more of the following outcomes: 1. Individual's linkage to the appropriate service(s) and support(s); 2. Completion of an initial evaluation/behavioral health assessment; 3. Completion of a psychiatric evaluation;	t 448-73
	 Authorization for services; Completion of two (2) face-to-face follow up appointments; and/or Individual reports feeling sufficiently supported and connected to desired services. 	Filed
o ionicional de la company de	Adults with a primary substance use, mental health, or co-occurring diagnosis who have been admitted to a crisis setting (CSU, BHCC, State contracted Community-Based Inpatient Psychiatric facility, DBHDD State Hospital, or Residential Detox) meeting one of the following frequency rates: 1. A 30-day readmission; or 2. Two (2) admissions within a 12-month period;	11/29/23
Criteria	 Other crisis utilization indicators, as evidenced by the following: a. Three (3) mobile crisis dispatches within 90 days or; b. Four (4) or more mobile crisis dispatches within nine (9) months; or c. Two (2) or more presentations at an emergency department within 90-days; and/or d. 30 consecutive days or more in a CSU or State contracted Community-Based Inpatient Psychiatric bed. 	Page 248
Continuing Stay	Individual remains disconnected from behavioral health community-based services and supports.	of 627

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High Utilizer	High Utilizer Management		
Discharge Criteria	 Individual has solidified recovery support networks to a Individual reports feeling sufficiently supported and co Documented multiple attempts (e.g., a minimum of for eight attempts over a two-month period) to locate and out/unsuccessful engagement after 90-days. 	assist in maintenance of recovery; and nnected to an aupports nnected to an appropriate level of services and supports Ir attempts over the first month, and/or a minimum of a make contact with an individual. The individual may be removed from the caseload due to drop	Case
Service Exclusions	1. This service may not duplicate any discharge planning efforts which are part of the expectation for hospitals, BHCCs, CSUs, and PRTFs. 2. The HUM program is available to individuals who have an authorization for ACT, CST, or ICM, and have not been actively engaged in services (as evidenced by not having at least one face-to- face contact within the past 30-days).	expectation for hospitals, BHCCs, CSUs, and PRTFs. or ICM, and have not been actively engaged in services (as evidenced by not having	e 1:16-
Clinical Exclusions	Individuals with the following conditions are excluded diagnosis of: a. Intellectual/Developmental Disabilities; and/or b. Autism; and/or c. Neurocognitive Disorder; and/or d. Transatio Brain Injury.	from admission unless there is clearly documented evidence of a psychiatric condition co-occurring with the	-cv-03088-EL
		stantiate eligibility for a behavioral health service.	?
	Provider organization must agree to promote HUM activities as an integrated service within the agency's continuum/system of care in order to promote engagement and successful ongoing connection. Each HUM Navigator will have access to, and/or receive a report generated daily of:	e within the agency's continuum/system of care in order to promote f:	Docur
	 Individuals assigned to their agency; and DBHDD hospital recidivism, specific to the individuals assigned to their agency. 		nent 4
	 HUM Navigators will maintain a short-term, rolling case load of individuals with whom active connection and reconnection services are being coordinated. The HUM program is expected to engage a high percentage of individuals into services with few dropouts. In the event that a HUM Navigator has documented another and/or a minimum of four attempts over the first month, and/or a minimum of eight attempts. 	m active connection and reconnection services are being coordinated. ices with few dropouts. In the event that a HUM Navigator has documented mum of six attempts over the first month, and/or a minimum of eight attempts.	148-73
	over a two-month period) to locate and make contact with an individual, and has demonstrated a diligent search, the individual may be removed from the caseload due to drop out/unsuccessful engagement after 90-days.	monstrated a diligent search, the individual may be removed from the caseload	File
Required Components	. 8	etwork. vidual for the following allowable expenses: I health, medical provider, or housing appointments. I)] prescription medication from retail pharmacies other than the provider's	ed 11/29/23
	pharmacy. c. Personal items - One (1) time purchase of necessary personal care items (e.g., basic clothing, grooming/hygiene items). d. Food - Light meal that is engagement-related with HUM navigator; maximum of \$8.00 per meal. e. Requisite benefits-related documentation - Obtaining birth certificate, state identification, etc.	g., basic clothing, grooming/hygiene items). of \$8.00 per meal. identification, etc.	Page
	HUM Navigators will use specified leveling in order to prioritize individuals based on the color coding below to identify barrier levels:	color coding below to identify barrier levels:	249 (
	Green – lowest level – mild barriers. Individual may have had previous service authorizations and/or an established connection to a provider; individual is known to the system, but not continuously and consistently engaging in community services that support stability; individual may have inadequate/inappropriate level of care; and/or individual may have refused services.	norizations and/or an established connection to a provider; individual is known to that support stability; individual may have inadequate/inappropriate level of	of 627

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	Yellow – mi authorized fi include char include char Red – highe medical corr	Yellow – mid level – moderate barriers. Individual may or may not have been authorized and/or engaged previously with provider, but is currently neither authorized for services nor connected, individual may have had inadequate/inappropriate level of care; individual may have refused services. Circumstances may include change in payor, financial limitations, location. Red – highest level – severe barriers. No current or previous authorization; individual may be homeless or have other unsafe/unstable housing, may present with medical complexity and/or co-occurring I/DD, involvement with criminal justice system or DFCS; individual may have inappropriate level of care; may have refused
	1. The practition 2. A full-time H Managemen 3. The followin PP	The practitioner who provides this service will be referred to in this definition as a HUM Navigator. A full-time HUM Navigator must be hired in accordance with Department determined criteria, and in collaboration with the Department's High Utilization Management Coordinator (HUMC). The following practitioners may provide HUM program services: Practitioner Level 2: Psychologist, APRN, PA Practitioner Level 3: LCSW, LPC, LMFT, RN Practitioner Level 4: LMSW: LAPC: LAMFT: Psychologist/LCSW/LPC/LMFT's supervisee/trainee with at least a Bachelor's degree in one of the helping
Staffing Requirements	• •	professions such as social work, community counseling, counseling, psychology, or criminology, functioning within the scope of the practice acts of the state; MAC, CAADC, CAC-II, GCADC (II, III); CPS, PP, CPRP or Addiction Counselor, psychology, or criminology. Training with at least a Bachelor's degree in practice acts of the helping professions such as social work, community counseling, counseling, psychology, or criminology. Practitioner Level 5: CPS; PP; CPRP; or, when an individual served has a co-occurring mental illness and substance use disorder: CAC-I, GCADC-I, or Addiction Counselor Trainee/Counselor in Training with high school diploma/equivalent under supervision of one of the licensed/credentialed
	4. Staff-to-cons rolling censu	HUM navigator shall be maintained at a minimum caseload of one HUM navigator serving 50 individuals (1:50). This is based on a rale identified in the Beacon system and/or by other enrolled providers who may serve as referral sources. Of these individuals, a services will be discharged and no longer counted in the ratio.
	It is not expe HUM Naviga school, religi HUM Naviga locations. HUM Naviga	It is <u>not</u> expected that HUM Navigators participate in or deliver clinical services. HUM Navigator service delivery may include (with appropriate consent) coordination with family and significant others and with other systems/supports (e.g., work, school, religious entities, law enforcement, aging agencies, etc.) when appropriate for services and supports. HUM Navigators must have the ability to deliver engagement services in various environments, such as inpatient, residential, homes, homeless shelters, or street locations. HUM Navigators must incorporate assertive engagement techniques to identify, locate, engage, and retain the most difficult to engage individuals who have a bistory of exclination and out of intensive services.
Clinical Operations	5. HUM Naviga collateral con Within 30 d Within 30 d Parental con collateral contractor co	HUM Navigators must demonstrate the implementation of well thought out engagement strategies, including the use of street and shelter outreach approaches and collateral contacts with family, friends, probation or parole officers. Using assertive engagement skills, the HUM Navigator will function to perform and report on the following 30-60-90 Day Activities: • have had face-to-face contact with individual • collaborate to identify most urgent needs • collaborate to identify barriers to access treatment/supports, prioritize services • report on progress

High Utilizer Management

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High Utilizer	High Utilizer Management	
	 connection to appropriate resources, services (as evidenced by attendance to appointments) convening appropriate parties, treatment providers, natural supports, stakeholders to identify and resolve barriers Within 90 days (Active Monitoring Engagement) Integration into appropriate level of services, supports and other resources. Monitor access and continued engagement in identified services/supports. Transition out of HUM program 	Case 1:1
	 HUM Navigators must: Use case management strategies to educate and connect to services and advocate for individuals. Utilize a person-centered approach to meet the needs of each unique person. Engage individuals who have not been successfully engaged into services beyond a crisis. Engage individuals who have not been successfully engagement to determine barriers to ongoing community-based care. Use conventional and unconventional methods of engagement to determine barriers to ongoing community-based care. Use a standardized comprehensive needs assessment tool. 	L6-cv-03088-ELR
	<u>ə</u>	Document
	 Elevate identified gaps in resources to the regional community collaboratives/local interagency planning team chairs to address and develop solutions with community partners; Reduce the number of people with elevated acute BH needs to improve access to care; Increase utilization and participation in programming that promotes stability, wellness and recovery; and/or Reduce the re-admission rates of individuals being re-admitted into BHCC, CSU, State/Private Hospital, PRTF levels of care. 	448-73 F
Service Accessibility	 There must be documented evidence that service hours of operation are flexible and include outreach and engagement during evenings and weekends. Demographic information collected shall include a preliminary determination of hearing-impairment status to determine the appropriateness of a referral to Deaf Services. HUM Navigators are expected to assertively engage with individuals in settings to include: Hospitals, BHCCs, CSUs, PRTFs, and other community settings. 	Filed 11/29
Documentation Requirements	 30/60/90-day reporting of progress Date of admission and discharge from HUM program Discharge Disposition: Still receiving services; Completed receiving services; Refused services; Incarcerated; or Other dispositions. Date of first and last HUM Navigator contact Unique identifier for each individual, which will follow them across multiple engagements 	9/23 Page 251 of 627

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High Utilize	High Utilizer Management	
	ID of HUM Provider (T1, T2+), perhaps Federal ID #?	
	Region	
	 County (where individual intends to reside while receiving services) 	(
	Urban vs. Rural (based on county)	Ca
	 Initial priority level coming into HUM (Red, Yellow, Green) 	se
	 Number and type of Crisis contacts - What factors placed them on the HUM list? 	1:
	• ER	16
	IP Stay (State contracted or DBHDD beds)	6-c
	• BHCC/CSU	:V-
	Residential Detox	03
	• PRTF	308
	Mobile Crisis	38-
	 Initial Barriers to engagement in community treatment (select as many as apply): 	ΕL
	• Homelessness	.R
	• Transportation	
	Inadequate DC planning	D
	Cultural factors	00
	Lack of understanding of value of OP services	ur
	Unavailability of services in community	ne
	Lack of knowledge in how to access state services	nt
	 Prior negative experience with community services 	44
	• Other	l8-
	 List of barriers that were successfully removed by the HUM Navigator/service. 	73
Billing &	Compliance with monthly programmatic reporting as requ	}
Renorting	Each HUM navigator must submit per unit encounters for	F
Requirements	3. Post 90-Day Review - The HUM Navigator will provide a monthly programmatic report to DBHDD of the caseload outcomes for individuals served in the HUM	iled
		1
Additional	None	1/2
Requirements		29/
		23

Housing Supplements	pplements													
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Code				2	3	4				1	2	3	_	
Housing							+000 01 +0 V							
Supplements							Actual cost							
Unit Value	1 day							Maximum Daily Units	1					
Service	This is a rental/housing su	ubsidy that n	nust be jus	stified by	a perso	nal cons	umer budget. ⁻	This is a rental/housing subsidy that must be justified by a personal consumer budget. This may include a one-time rental payment to prevent eviction/homelessness.	tal payme	int to pre	event ev	iction/h	seles	sness.

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The Housing S	Code Detail	Code	Mod I	Mod 2	Mod I	Mod 4	Rate	Code Detail	Code	Mod 1	Mod 2	Mod Mod 3 4	od Rate
The Housing S													
In its fullness, individuals ent engage in the is not continge	The Housing Support program represents a critical of its fullness, this program is comprised of recovery individuals entering the Georgia Housing Voucher Pengage in the Housing Support program in order to is not contingent upon the acceptance of treatments	prisents a prised of relousing Vologram in o	critical concerving the control of t	supports supports ogram (r romote a	s to sust GHVP) c commur in accor	rmanen tain perr or renev or renev ity intec	t Supportive nanent hous ving their les gration, coor with the Hou	The Housing Support program represents a critical component of Permanent Supportive Housing as outlined in the Evidence Based Practices Toolkit from SAMHSA. In its fullness, this program is comprised of recovery supports to sustain permanent housing. The Housing Support program is a required element of the program for all individuals entering the Georgia Housing Voucher Program (GHVP) or renewing their lease under GHVP, as of April 1, 2022. All enrolled individuals are expected to engage in the Housing Support program in order to promote community integration, coordination of desired services, and long-term housing stability. Access to housing is not contingent upon the acceptance of treatment services, in accordance with the Housing First philosophy and approach.	lence Basec ram is a req 2022. All en Id long-term bach.	d Practic luired el rolled in housino	ces Toc lement idividua g stabili	olkit from of the programs als are exity. Accestify.	SAMHSA. gram for all bected to s to housing
The Housing Songoing housing Sorvice 3. Safe 3. Safe 5. Early 6. Eduly 7. Assistant 1. Com 2. Land 3. Coac 3. Coac	sing Support program is comprised of multiple supports designed to assist individual subsing stability. All individuals enrolled in the Housing Support program must recassistance with housing search, leasing, and move-in processes; Purchase of initial household furnishing, deposits, household goods for the one-til Safety and wellness checks and housing safety inspections; Developing a Housing Stability Support Plan as an adjunct to an individual's IRP; Early intervention to mitigate factors impacting housing stability (e.g., late rent particular on the roles, responsibilities, and rights of tenant(s) and the landlord/prassistance with the annual housing recertification and inspection process. Auals enrolled in the Housing Support program shall receive any of the following su Completion of supportive housing referral and application processes; Landlord engagement, recruitment, and enrollment; Coaching on relationship-building with landlords/property owners, managers, and	iduals enro search, les search, les cks and ho tability Sup gate factor gate factor esponsibili al housing r sing Suppo e housing r ecruitment,	of multip blled in that assing, ar- shing, del busing se pport Plan se impacti ities, and ities, and it progra eferral an and enra	le suppx de Housing housests, hately instance posits, hately instance in as an ing hous rights of cation a mashall me shall ollment; ords/produce in the house in the shall of	orts desi ing Supt in proce nousehol pections adjunct i sing stab of tenant and inspe receive cation pr	igned to port pro- esses; Id goods; it to an in- oility (e.g. and estrion pri any of t	assist indiv gram must r s for the one dividual's IR 3., late rent t the landlord rocess. he following s;	The Housing Support program is comprised of multiple supports designed to assist individuals living in GHVP-subsidized permanent supportive housing to promote ongoing housing stability. All individuals enrolled in the Housing Support program must receive the following types of support: 1. Assistance with housing search, leasing, and move-in processes; 2. Purchase of initial household furnishing, deposits, household goods for the one-time move-in needs; 3. Safety and wellness checks and housing safety inspections; 4. Developing a Housing Stability Support Plan as an adjunct to an individual's IRP; 5. Early intervention to mitigate factors impacting housing stability (e.g., late rent payment, lease violations, tenant/landlord or property owner conflicts); 6. Education on the roles, responsibilities, and rights of tenant(s) and the landlord/property owner; and 7. Assistance with the annual housing recertification and inspection processes; 8. Completion of supportive housing referral and application processes; 9. Landlord engagement, recruitment, and enrollment; 10. Completion or letationship-building with landlords/property owners, managers, and neighbors, and assisting in dispute resolution; and	d permanen pport: nt/landlord o eds and pre	r proper	ortive horty own rty own ss:	ousing to	promote (s);

Individuals with the following conditions are excluded from admission unless there is clearly documented evidence of psychiatric condition co-occurring with one of the

following diagnoses: Developmental Disability, Autism, Neurocognitive Disorder, Traumatic Brain Injury.

Individual has acquired natural supports that supplant the need for this service.

Individual requests discharge; or

-: ~:

Discharge

Criteria Clinical

Individual has developed a Recovery goal to develop natural supports that promote the family/caregiver-management of these needs.

Based upon a personal budget, individual has a need for financial support for a living arrangement.

Individual meets target population as identified above; and

←. ८.

Admission

Criteria

Continuing Stay

Criteria

Individual continues to meet admission criteria as defined above; and

If the individual supported is sharing rent with another person, then agency may only utilize and report the assistance provided to the served individual (rounded to

The individual clinical record must have documentation of the actual payment by the agency to the leaser/landlord. A receipt for this payment must also be kept in

the clinical record.

the nearest dollar)

Documentation Requirements

Exclusions

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m rd}$ Quarter Provider Manual for Community Behavioral Health Providers (January 1, 2023)

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Behavioral Health Residential Programs are excluded (MH or SUD).	Service Exclusions
Individual no longer meets admission criteria.	Discharge Criteria
Individual continues to meet admission criteria.	Continuing Stay Criteria
 Individual must be 18 or older and have a severe and persistent mental illness (SPMI). Individual must be enrolled in the Georgia Housing Voucher Program (GHVP). Includes individuals with a Notice to Proceed for GHVP, meaning those who have received a voucher and are in the housing search process. 	Admission Criteria
 Addictive Disease Support Set vices (ADSS) Crisis Intervention Community Residential Rehabilitation (CRR-IV) Community Transition Planning (CTP) 	
Specific allowable DBHDD behavioral health services (see the Service Definition/Requirements for each service listed below in this Provider Manual): 1. Case Management (CM) 2. MH and/or SUD Peer Supports (PS) 3. Psychosocial Rehabilitation – Individual (PSR-I)	
The Housing Support program is comprised of a group of interventions including items 1-8 below as well as elements which are defined herein which are not billable via traditional rehabilitation codes. Supports are based on individual need and could include (but are not limited to) the coordination of DBHDD services with community services/supports and financial assistance to help offset the costs of an approved provider's staff time for non-billable activities such as travel, meeting and conference attendance, trainings, and other related activities.	
This program is provided to adults enrolled in GHVP in order to promote housing stability, wellness, independence, recovery, and community integration. Housing stability is measured by ongoing housing and by decreased number of hospitalizations/ER visits/incarcerations, by decreased frequency and duration of crisis episodes, and by increased and/or stable participation in maintenance of personal housing stability and wellness. Supports based on the individuals' needs are used to promote resiliency while understanding the effects of SPMI and lived trauma. The Housing Support staff will serve as the first point of contact for landlords/property owners for any issues arising with a supportive housing individual, and will provide linkage to community; general entitlements; and psychiatric, substance use disorder, medical services, crisis prevention, and intervention services.	

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	1. The Housing Support program must be provided through a team approach (as evidenced in documentation). It focuses on building and maintaining a positive relationship with the individual, facilitating needed independent living supports, and working toward recovery goals.	
	The Housing Support program must include a variety of interventions in order to assist the individual in developing:a. Recovery orientation and skills to work toward their personal recovery goals related to their ability to live independently.	Cas
		se 1
	 Strategies and supportive interventions for developing positive relationships/avoiding conflicts with neighbors and property owner. Relapse prevention strategies and plans. 	L:16
	Ei	6-c\
		/-0
		30
	c. Confirmanity integration and relationships with property/neignbors, d. Household financial stability.	88-
Required	4. Contact requirements for individuals receiving the Housing Support program:	EL
Components	a. Contact must be made a minimum of once a week during the first three months of being housed to ensure individuals remain stabilized,	R
		Do
	c. Half of these contacts must be face-to-face and the other half may be either face-to-face or telephone contact depending on the individual's support needs	ocui
	and documented preferences. 5. At least 50% of HSI service units must be delivered face-to-face with the identified individual receiving the service and at least 80% of all face-to-face service units	me
	must be delivered in the individual's home over the authorization period (these units are specific to single individual records and are not aggregate across an	nt 4
		148
	 In the absence of the required monthly tace-to-race contact and if at least two unsuccessful attempts to make face-to-race contact have been tried and documented the provider may hill for a maximum of four telephone contacts in that specified month 	3-73
	7. Unsuccessful attempts to make contact with the individual are not billable.	3
	8. DBHDD services provided via the Housing Support service must adhere to all DBHDD service definitions and requirements for each service provided.	Fil
	1. Housing Support providers must, at a minimum, have the following positions on staff: a. 1 FTE Program Director dedicated (licensed: LCSW: LPC. or LMFT): and	ed 1
	b. At least 1 FTE Housing Specialist/Case Manager (practitioners who can provide Case Management services as defined in the BH Provider Manual) who is	1/2
		9/2
Statiling Requirements	 Peer Support is a critical component of recovery. Individuals being served by a Housing Support provider must have access to a CPS-MH that can provide Peer. Support services. There must be documented engagement by the staff team with a CPS-MH. 	23
		P
	 Provider must adhere to the Staffing Requirements section of the Service Definition/Requirements for the specific DBHDD service being provided, as well as to all other staffing/professional requirements found elsewhere in the DBHDD's Provider Manual for Community Based Behavioral Health Providers. 	age
	- H	25
	 To promote access, providers may use Telemedicine as a tool to provide direct interventions to individuals for whom English is not their first language. Examples of this include: 	5 of
Accessibility	 the use of one-to-one service intervention via Telemedicine, connecting the individual to a practitioner who speaks the individual's language versus use of interpreters: and/or 	627
	 the use of an interpreter via Telemedicine to support the practitioner in delivering the identified service. 	7

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Housing Su	Housing Support (Effective January 1, 2023)	
	Telemedicine may only be utilized when delivering this service to an individual for whom English is not their first language. The individual must consent to the use of this modality. This consent should be documented in the individual's record. The use of telemedicine should <u>not</u> be driven by the practitioner's/agency's convenience or preference.	Cas
	2. If any of the individually billed services named herein have more restrictive telemedicine expectations, then those shall supersede item 1 above.	e
	1. There must be an individual record that includes documentation of supports described in this program guideline.	1:1
	 Provider is required to complete a progress note for every nousing support mervenion on behalf of the individual that does not align with one of the eight services outlined above. 	6-c
	3. Progress notes must adhere to the documentation requirements set forth in this manual.	:v-C
Documentation Requirements	4. A monthly programmatic report is required that will aggregate any generalized activities conducted on behalf of individuals which do not align with the one of the services outlined above.	308
	5. Housing Support program staff must comply with any data collection expectations in support of the program's implementation and evaluation strategy. 6. The individual's clinical record contains a Housing Stability Support Plan as an adjunct to the Individualized Recovery Plan, which is no more than 12 months old and which is updated when there is a demand for change in said plan.	8-ELR

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1. The majority of interventions defined herein are billable through the codes named here:

Service	Maximum Authorization Units	Daily Maximum Billable Units
Case Management (CM)	140 for 6 months	24
MH and/or SUD Peer Supports (PS)	520 for 6 months	48
Psychosocial Rehabilitation – Individual (PSR-I)	300 for 6 months	48
Addictive Disease Support Services (ADSS)	100 for 6 months	48
Crisis Intervention	64 for 6 months	16
Community Support – Individual (CSI)	100 for 6 months	48
Community Residential Rehabilitation (CRR-IV)	36 for 6 months	8
Community Transition Planning (CTP)	32 for 6 months	24

DBHDD service provision, billing, and reporting must adhere to all DBHDD and Georgia Collaborative ASO requirements.

Requirements Billing & Reporting

Provider must submit a monthly invoice, invoice justification/supporting documentation (as needed), and a programmatic report to their designated DBHDD contract manager. ر ا دن

Providers are required to maximize utilization of alternative funding streams, including third party payers (e.g., Medicaid, private insurance, etc.), public targeted and competitive grants, and private foundation funds. 4.

to the daily maximum amount for each service. The overall Housing Support Program must follow the content of this Service Guideline, while any specific services Approved providers of this program may submit claims/encounters for the unbundled services listed in the table above, in accordance with individual need, and up delivered as part of the program but billed separately (i.e., those listed in the table above) must also comply with their specific service guidelines found elsewhere in this Manual. 5

The billable activities of the Housing Support program do not include: <u>ن</u>

Transportation.

Expenses covered under Bridge Funding services.

Generalist engagements/interactions with landlords to build capacity, i.e., landlord interactions must be specific to an individual's IRP in order to be billable.

Intensive Ca	Intensive Case Management													
Transaction Code	Code Detail	Code	Mod 1	Mod 2	ModModModRate234	Mod 4	Rate	Code Detail	Code Mod Mod Mod Rate	Mod 1	Mod Mod Mod Mo	Mod 3	Mod 4	Rate
	Practitioner Level 4, In-Clinic	T1016 HK	关	U4 U6	90		\$20.30	Practitioner Level 4, In-Clinic, Collateral Contact	T1016 HK UK U4 U6 \$20.30	关	¥	D4	90	\$20.30
Intensive Case	Practitioner Level 5, In-Clinic	T1016 HK	关	US U6	90		\$15.13	Practitioner Level 5, In-Clinic, Collateral Contact	T1016 HK UK U5 U6 \$15.13	关	N.	O.S	90	\$15.13
Management	Practitioner Level 4, Out-of-Clinic	T1016 HK	关	U4 U7	U7		\$24.36	Practitioner Level 4, Out-of-Clinic, Collateral Contact	T1016 HK UK U4 U7 \$24.36	关	UK	U4	U7	\$24.36
	Practitioner Level 5, Out-of-Clinic	T1016 HK	关	U5 U7	U7		\$18.15	Practitioner Level 5, Out-of-Clinic, Collateral Contact	T1016 HK U5 U7 \$18.15	关	¥	O.S	U2	\$18.15

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Intensive Ca	Intensive Case Management										-			
	Practitioner Level 4, Via interactive audio and video telecommunication systems	T1016	GT	关	U4 \$	\$20.30	Practitioner Level 5, Via interactive audio and video telecommunication systems	a interactive nmunication	T1016	GT	关	US	\$15.13	က
Unit Value	15 minutes						Utilization Criteria		TBD					
	Intensive Case Management consists of providing environmental supports and care coordination considered essential to assist a person with improving his/her functioning, gaining access to necessary services, and creating an environment that promotes recovery as identified in his/her Individual Recovery Plan (IRP). The focus of the interventions includes assisting the individual with: 1) developing natural supports to promote community integration; 2) identifying service needs; 3) referring and linking to services and resources identified through the service planning process; 4) coordinating services identified on the IRP to maximize service integration and minimize service gaps; and 5) ensuring continued adequacy of the IRP to meet his/her ongoing and changing needs.	ists of pro essary ser assisting d resource aps; and t	widing e rvices, a the indives identification (2) ensuring (2) ensuring (3)	nvironn ind cres idual w ified thr ing con	nental supports tting an environ vith: 1) developi ough the servic tinued adequac	and care iment tha ing nature is plannin	vironmental supports and care coordination considered essential to assist a ped creating an environment that promotes recovery as identified in his/her Individual with: 1) developing natural supports to promote community integration; 2) ied through the service planning process; 4) coordinating services identified on ig continued adequacy of the IRP to meet his/her ongoing and changing needs	ed essential to identified in h community inte ting services ic	assist a is/her Incegration; Jentified	person dividual I 2) identi on the IF	with imp Recover fying se RP to m	oroving his ry Plan (IF ervice nee aximize s	s/her RP). The ds; 3) ervice	
	The performance outcome expectations for individuals receiving this service include decreased hospitalizations, decreased incarcerations, decreased episodes of homelessness, increased housing stability, increased participation in employment activities, and increased community engagement.	ations for stability, i	individu: ncrease	als rece d partic	iving this servic	se include oyment a	s receiving this service include decreased hospitalizations, decreased incarcer participation in employment activities, and increased community engagement.	tions, decreas community er	ed incan ngageme	serations int.	s, decre	ased epis	odes of	
	Intensive Case Management shall consist of four (4) major components and cover multiple domains that impact one's overall wellness including medical, behavioral, wellness, social, educational, vocational, co-occurring, housing, financial, and other service needs of the individual:	consist of tional, co-	f four (4) occurrir	najor ng, hous	components ar. sing, financial, a	nd cover r and other	nultiple domains that in service needs of the in	npact one's ov idividual:	erall wel	lness inc	luding 1	nedical, b	oehavioral	
	Engagement & Needs Identification The case manager engages the individual in a recovery-based partnership that promotes personal responsibility, and provides support, hope and encouragement. The case manager engages the individual with developing a community-based support network to facilitate community integration and maintain housing stability. Through engagement, the case manager partners with the individual to identify and prioritize housing, service, and resource needs to be included in the IRP.	<u>tion</u> dividual ir al with dev artners wit	ra recov veloping th the inc	/ery-ba: a comr dividual	sed partnership nunity-based si to identify and	that pror upport ne prioritize	motes personal respons twork to facilitate comn housing, service, and r	sibility, and pro nunity integrat esource need	ovides su ion and r s to be ir	ipport, hi naintain ncluded i	ope and housing in the IF	l encouraç g stability. RP.	gement. T Through	 he
Service Definition	Care Coordination The case manager coordinates care activities and assist the individual as he/she moves between and among services and supports. Case Coordination requires information sharing among the individual, his/her Tier 1 or Tier 2 provider, specialty provider(s), residential provider, primary care physician, and other identified supports in order to: 1) ensure the individual receives a full range of integrated services necessary to support a life in recovery including health, home, purpose, a community; 2) ensure the individual has an adequate and current crisis plan; 3) reduce barriers to accessing services and resources; 4) minimize disruption, fragmentation, and gaps in service; and 5) ensure all parties work collaboratively for the common benefit of the individual.	re activitie ividual, hie individual il has an e	es and a s/her Tie receive adequate nsure al		e individual as l Fier 2 provider, range of integra urrent crisis pla urvent collabora	he/she m specialty ated servi in; 3)redu atively for	sist the individual as he/she moves between and among services and supports. Case Coordination requires 1 or Tier 2 provider, specialty provider(s), residential provider, primary care physician, and other identified a full range of integrated services necessary to support a life in recovery including health, home, purpose, and and current crisis plan; 3)reduce barriers to accessing services and resources; 4) minimize disruption, parties work collaboratively for the common benefit of the individual.	ong services ar provider, prim ort a life in rec g services anc	nd suppc lary care overy inc d resourc	orts. Cas physicia :luding h es; 4) m	se Coorin, and inealth, historianize	dination reother ider other ider ome, purl disruption	equires htified pose, and n,	
	Referral & Linkage The case manager assists the individual with referral supports, entitlements (e.g., SSI/SSDI, Food Stamps, available resources; 2) make and keep appointments;	vidual witl SDI, Fooc eep appc	h referra 1 Stamp: sintment		nkage to servico income, transpo mplete intake s	es and re: ortation, e and applic	and linkage to services and resources identified on the IRP including housing, social supports, family/natural , VA), income, transportation, etc. Referral and linkage activities may include assisting the individual to: 1) locate ; 3) complete intake and application processes and 4) arrange transportation when needed.	ie IRP includir je activities ma) arrange trans	ig housir ay includ sportatior	ıg, socia e assistii ı when n	l suppoi ng the i	rts, family ndividual 1	/natural to: 1) loca	<u></u>
	Monitoring & Follow-Up The case manager visits the individual in the community to jointly review progress toward achievement of IRP goals and to seek input regarding his/her level of satisfaction with treatment and any recommendations for change. The case manager monitors and follows-up with the individual in order to: 1) determine if services are provided in accordance with the IRP; 2) determine if services are adequately and effectively addressing the individual's needs; 3) determine the need for additional or alternative services related to the individual's changing needs or circumstances; and 4) notify the treatment team when monitoring indicates the need for an IRP reassessment and update.	dual in the recomme e IRP; 2)	e commu endatior determir al's chai	unity to is for character is for character if sei no nging n	jointly review parange. The castorices are adequeds or circumiceds or circumiceds.	rogress to se manag luately an stances; ¿	ity to jointly review progress toward achievement of IRP goals and to seek input regarding his/her level of for change. The case manager monitors and follows-up with the individual in order to: 1) determine if services it services are adequately and effectively addressing the individual's needs; 3) determine the need for additior ging needs or circumstances; and 4) notify the treatment team when monitoring indicates the need for an IRP	RP goals and s-up with the ir g the individua	to seek ndividual I's needs noniton	input reg in order s; 3) dete ing indic	arding l to: 1) d ermine t cates th	nis/her lev etermine he need f e need fo	rel of if services or additior r an IRP	lar

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Ve Case Mana 1. Individ 2. Individ a. b. c. c. d. f. f. f. which Needs a. c. c.	 d. Care for personal business affairs; e. Obtain or maintain medical, legal, and housing services; f. Recognize and avoid common dangers or hazards to self and possessions; g. Perform daily living tasks; h. Obtain or maintain employment at a self-sustaining level or consistently perform homemaker roles (e.g., household meal preparation, washing clothes, budgeting, or childcare tasks and responsibilities); i. Maintain a safe living situation (e.g., evicted from housing, or recent loss of housing, or imminent risk of loss of housing); AND 4. Individual is engaged in their Recovery Plan but needs assistance with one (1) or more of the following areas as an indicator of demonstrated ownership and engagement with his/her own illness self-management: a. Taking prescribed medications, or 	 b. Following a crisis plan, or c. Maintaining community integration, or d. Keeping appointments with needed services which have resulted in the exhibition of specific behaviors that have led to two or more of the following within the past 18 months: i.Hospitalization. ii.Incarceration. iii.Homelessness, or use of other crisis services (i.e., CSU, ER, etc.). 	 Individual continues to have a documented need for an ICM intervention at least four (4) times monthly. AND Individual continues to demonstrate significant functional impairment as demonstrated by the need for assistance in 2 or more of the following areas which, despite support from a caregiver or behavioral health staff continues to be an area that the individual cannot complete. Needs significant assistance to:
Intens	Admission Criteria		Continuing Stay Criteria

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≥ j	
ש ת	Individuals with the following conditions are excluded from admission <u>unless</u> there is clearly documented evidence of a psychiatric condition co-occurring with the diagnosis of:
	Intellectual/Developmental Disabilities; and/or
ς 6	Autism; and/or Neurocognitive Disorder; and/or
- 1	
	The ICM service can only be provided by a Tier I or Tier II DBHDD contracted provider.
	Each provider must have policies and procedures related to referral including providing outreach to agencies who may serve the targeted population, including but
	not limited to psychiatric inpatient hospitals, Crisis Stabilization Units, jails, prisons, homeless shelters, etc. Demonstrate and maintain a time frame from receipt of referral to engagement into services with an individual of no more than 5 days.
	The organization must have policies and procedures for protecting the safety of staff that engage in these community-based service delivery activities.
	Individuals will be provided assistance with gaining skills and resources necessary to obtain housing of the individual's choice, including completion of the housing and obtain choice, including completion of the housing
	need and choice survey (<u>migs.//doinddapps.doi//vsrr/</u>) upon admission and with the development of a nodsing goal, which will be fillingly updated at each reauthorization.
	Maintain face-to-face contact with individuals receiving Intensive Case Management services, providing a supportive and practical environment that promotes
	recovery and maintain adherence to the desired performance outcomes that have been established for individuals receiving ICM services. It is expected that
	frequency of face-to-face contact is increased when clinically indicated in order to achieve the performance outcomes, and the intensity of service is reflected in the individual's IRP
_	A minimum of 4 face-to-face visits must be delivered on a monthly basis to each consumer. Additional contacts may be either face-to-face or telephone collateral
	contact depending on the individual's support needs, 60% of total units must be face-to-face contacts with the individual.
	At least 50% of all face-to-face service units must be delivered in non-clinic/community-based settings (i.e., any place that is convenient for the individual such as a
	ranc, place of employment, community space) over the authorization period (these units are specific to single individual records and are not aggregate across an agency/program or multiple pavers).
6	In the absence of monthly face-to-face contacts and if at least two unsuccessful attempts to make face-to-face contact have been tried and documented, the
	provider may bill for a maximum of 2 telephone contacts in that specified month (denoted by the UK modifier). This may occur for no more than 60 consecutive
10	days. After 8 unsuccessful attemnts at making face to face contact with an individual the ICM and members of the treatment/support team will re-evaluate the standing
	IRP and utilization of services.
Ξ.	
	drop out.
- :	12. Individuals for whom there is a written transition/discharge plan may receive a tapered benefit based upon individualized need as documented in that plan.
	. Team meetings must be held a minimum of once a week and time dedicated to discussion of support and service to individuals must be documented in the Treatment Team Meeting I on Each individual must be discussed even if brighty at least one time monthly ICM staff members are expected to after Treatment
	neament ream meetings buy. Each mulatud mast be discussed, even in biletiy, at least one mile monthly. Dom star members are expected to attend the amment. Team Meetings.
	The following practitioners may provide ICM services:
	a. Practitioner Lever 1. Fritysidal/Psychiatrist (Termbursed at Lever 4 rate). b. Practitioner Level 2: Psychologist, APRN, PA (reimbursed at Level 4 rate).
	c. Practitioner Level 3: LCSW, LPC, LMFT, RN, or when an individual served is diagnosed with a co-occurring mental illness and substance use disorder:
	MAC, CAADC, GCADC-11 of -111, of CAC-11 (Tellifoursed at Level 4 fate).

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Intensive Case Management	se Ma	nagement
	d. Eac e. Direction of the contraction of the contr	 d. Practitioner Level 4: LMSW; LAPC; LAMFT; Psychologist/LCSW/LPC/LMFT's supervisee/trainee with at least a Bachelor's degree in one of the helping professions such as social work, community counseling, psychology, or criminology, functioning within the scope of the practice acts of the state; CPS, Paraprofessional, CPRP, or when an individual served is diagnosed with a co-occurring mental illness and substance use disorder: GCADC-I (with Bachelor's Degree), or Certified Alcohol and Drug Counselor Trainee/Counselor in Training (with Bachelor's Degree), CAC-I (without Bachelor's Degree), or Certified Alcohol and Drug Counselor in Training (with Bachelor's Degree), cAC-I (without Bachelor's Degree), or Certified Alcohol and Drug Counselor-Trainee/Counselor in Training (without Bachelor's Degree), CAC-I (without Bachelor's Degree), or Certified Alcohol and Drug Counselor-Trainee/Counselor in Training (without Bachelor's Degree), CAC-I (without Bachelor's Degree), or Certified Alcohol and Drug Counselor-Trainee/Counselor in Training (without Bachelor's Degree), CAC-I (without Bachelor's Degree), or Certified Alcohol and Drug Counselor-Trainee/Counselor in Training (without Bachelor's Degree), CAC-I (without Bachelor's Degree), or Certified Alcohol and Drug Counselor-Trainee/Counselor in Training (without Bachelor's Degree), cAC-I (without Bachelor's
	e. 3. Ove 4. Sta are	 Certified Alcohol and Drug Counselor-Trainee Oversight of an intensive case manager is provided by an independently licensed practitioner. Staff to consumer ratio for ICM services shall be a maximum caseload of 1:20 quarterly in rural areas and 1:30 in urban areas. Winimum caseloads in rural areas are 1:15 and 1:25 in urban areas. Urban counties are delineated in the annual Georgia County Guide with the term "Metropolitan County".
Clinical Operations	2. 7. 3. 4. 3. 4. 5. 6. 6. 6. 6. 6. 6. 6. 6. 6. 6. 6. 6. 6.	CIM may include (with the consent of the Adult) coordination with family and significant others and with other systems/supports (e.g., work, religious entities, corrections, aging agencies, etc.) when appropriate for treatment and recovery needs. Corrections, aging agencies, etc.) when appropriate for treatment and recovery needs. Corrections, aging agencies, etc.) when appropriate for treatment and recovery needs. Individuals may prefer to meet staff at a community location of ther than their homes or other conspicuous locations (e.g. their place of employment), especially if staff drive a vehicle that is clearly marked as a state or agency vehicle, or if staff must identify themselves and their purpose to gain access to the individuals in a way that may potentially embarrass the individual or breech the individuals privacy/confidentiality rights and preferences in this regard to the greatest extent possible (e.g., if staff must meet with an individual during their work individual wishes, mutually agree upon a meeting place nearby that is the least conspicuous from the individual spoint of view). ICIM must locational wishes, mutually agree upon a meeting place nearby that is the least conspicuous from the individual swho cycle in and out of intensive services. ICIM must demonstrate the implementation of well thought out engagement strategies to minimize discharges to do not out including the use of street and shelter outreach approaches and collateral contacts with family, friends, probation or parole officers. ICIM is expected to actively and assertively participate in transition planning via plan for timely follow up on refernals to and from their service, making sure individuals are connected to resources to meet their needs in alignment with their preferences. The team is responsed to actively and assertively barmacy, benefits, a support network and refer plan propriated or community paychiatric hospital, released from jail; or expected to actividate in discharge planning meetings while the individual

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Intensive Ca	Intensive Case Management	
	a. The organization jointly develops the crisis plan in partnership with the individual. The organization is engaged with the individual to ensure that the plan is	
	complete, current, adequate, and communicated to all appropriate parties. b There is evaluation of the adequacy of the individual's crisis plan and its implementation at periodic intervals including post-crisis events.	
	i. While respecting the individual's crisis plan and identified points of first response, the policies should articulate the role of the Tier 1 or Tier 2 provider	C
		as
	ii. Describe methods for supporting individuals as they transition to and from psychiatric hospitalization/crisis stabilization.	se í
	/ The organization must have an ICM Organizational Plan that addresses the following:	1:1
	a. Description of the role of ICM during a crists in partnership with the individual, and Tier Lor Tier z provider of other clinical home service provider where the individual receives ongoing physician assessment and treatment as well as other recovery supporting services.	6-c
	b. Description of the staffing pattern and how staff are deployed to assure that the required staff-to-individual ratios are maintained, including how unplanned staff	:v-C
	absences, illnesses, or emergencies are accommodated, case mix, access, etc.)30
		380
	d. Description of how the IRP plan constructed, modified and/or adjusted to meet the needs of the individual and to facilitate broad natural and formal support	3-E
		ELI
	e. Description of how ICM agencies engage with other agencies who may serve the target population.	R
	There must be documented evidence that service hours	
	2. To promote access, providers may use Telemedicine as a tool to provide direct interventions to individuals for whom English is not their first language. Examples	Do
		CL
	• the use of one-to-one service intervention via Telemedicine, connecting the individual to a practitioner who speaks the individual's language versus use	ım
Service	of interpreters; and/or	en
Accessibility	 the use of an interpreter via Telemedicine to support the practitioner in delivering the identified service. 	ıt 4
		48
		3-7
	of this modality. This consent should be documented in the individual s record. The use of telemedicine should <u>not</u> be driven by the practitioner stagency s	3
0	1. When a billable collateral contact is provided, the UK reporting modifier shall be utilized. A collateral contact is classified as any contact that is not face-to-face with	Fi
Billing & Donorting	the individual.	led
Requirements	2. When Telemedicine technology is utilized for the provision of this service in accordance with the allowance in the Service Accessibility section of this definition, the	d 1
	code cited in the Code Detail above with the appropriate GT modifier shall be utilized in documentation and claims submission.	1/2
		29/2
Medication	Medication Assisted Treatment	23

Medication	Medication Assisted Treatment							
Transaction Code	Code Detail	Code	Mod 1	Mod 2	Mod Mod Mod Mod	lod	Rate	`
	See TOC Grid in Part I of this Manual for Services Billing detail.	of this Manual for Se	ervices E	Billing d	etail.			
Service Definition	Medication Assisted Treatment (MAT) provides specific interventions for reducing and/or eliminating the use of illicit opioids and other drugs of abuse; while developing the individuals social support network and necessary lifestyle changes; psychoeducational skills; pre-vocational skills leading to work activity by reducing substance use as a barrier to employment; social and interpersonal skills; improved family functioning; the understanding of substance use disorders; and the continued commitment to a recovery and maintenance program. MAT is a multi-faceted approach treatment service for adults who require structure and support to achieve and maintain recovery from Opioid Use Disorder. The following elements of this service model include:	ions for reducing and/canges; psychoeducation proved family function nulti-faceted approach ents of this service moderness.	or elimina nal skills ning; the treatmen del includ	ating the s; pre-vorunderstant service nt servicede:	use of illic cational sk anding of s e for adults	it opioid ills lead ubstanc s who re	ic interventions for reducing and/or eliminating the use of illicit opioids and other drugs of abuse; while developing ifestyle changes; psychoeducational skills; pre-vocational skills leading to work activity by reducing substance and skills; improved family functioning; the understanding of substance use disorders; and the continued MAT is a multi-faceted approach treatment service for adults who require structure and support to achieve and wing elements of this service model include:	

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Medication	Medication Assisted Treatment	
	 Physician Assessment; Nursing Assessment; Nursing Assessment; Medication Administration; Opioid Maintenance; Diagnostic Assessment; Individual Counseling; Group Outpatient Services (including psycho-educational groups focusing on relapse prevention and recovery); Addictive Disease Support Services; and Addictive Disease Support Services; and Behavioral Health Assessment & Service Planning Development. Additionally, the following services maybe provided: Crisis Intervention; Peer Support 	Case 1:16-cv-03088-El
Admission Criteria		R Documer
Continuing Stay Criteria Discharge Criteria	Individual continues to meet the criteria for admission. An adequate continuing care or discharge plan is established and linkages are in place; and one or more of the following: 1. Goals of the individualized recovery plan have been met; and 2. The individual consistently fails to adhere to the program rules and guidelines; or	nt 448-73
Service Exclusions	 Individual requests discharge and the individual is not in imminent danger of harm to self or others; or Transfer to another service/level of care is warranted by change in individual's condition. Infectious Diseases screenings such as (HIV, TB) are not billed as service interventions which are covered by this service definition. The provision of the program, but do not qualify as a specific billable service intervention of take-home medication is not billed as a type of service intervention which is covered by this service intervention to the DBHDD. Provised by work and tasting for this service are not fullable to this service code. 	Filed 11/29/23
Required Components	다 2 4 t ii 다 4 si si 다	Page 264 of 627

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Documentation must support the medical necessity of administration by licensed/credentialed medical personnel rather than by the individual, family Documentation must support that the individual is being trained in the principle of self-administration of medication or that the individual is physically disorder, or to the treatment of the disorder (e.g. diabetes, cardiac and/or blood pressure issues, substance withdrawal symptoms, weight gain and Consulting with the individual and individual-identified family and significant other(s) about medical, nutritional and other health issues related to th Educating the individual and any identified family about potential medication side effects (especially those which may adversely affect health such In addition to the above required activities within the program, the following must be offered as needed either within the program or through referral to/or affiliation There must be a written service order for Medication Administration and a written order for the medication and the administration of the medication Assessing and monitoring an individual's medical and other health issues that are either directly related to the mental health or substance related Assessing and monitoring individual's response to medication(s) to determine the need to continue medication and/or to determine the need to or mentally unable to self-administer. This documentation will be subject to scrutiny by the Administrative Service Organization in reauthorizing Consulting with the individual and the individual-identified family and significant other(s) about the various aspects of informed consent (when This service requires face-to-face contact with the individual to monitor, evaluate, assess, and/or carry out a physician's orders regarding the physical Individual counseling in exceptional circumstances for traumatic stress and other mental illnesses for which special skills or licenses are required. Providing nursing assessments and interventions to observe, monitor and care for the physical, nutritional, behavioral health and related as weight gain or loss, blood pressure changes, cardiac abnormalities, development of diabetes or seizures, etc.) The program must have a Medication Assisted Treatment Services Organizational Plan addressing the following: psychosocial issues, problems or crises manifested in the course of an individual's treatment; Service coordination and engagement unless provided through another service provider; and hat complies with guidelines set forth herein Part II, Section 1, Subsection 6 - Medication. with another agency or practitioner, and may be billed in addition to the billing for MAT: Behavioral Health Assessment & Service Plan Development: individual's mental health or substance related issues; and/or psychological problems of the individual. It includes: AD Support Services – for housing, legal and other issues. Training for self-administration of medication. Complete and fully document physical exam; Medication Administration & Opioid Maintenance: refer the individual for a medication review; Individualized recovery planning; and Physician assessment and care; Assessment and reassessment; fluid retention, seizures, etc.); Service plan development. prescribing occurs); and services in this category. Linkage to health care. Health screening. Physician Assessment: Nursing Assessment: or caregiver; ∷≡ .<u>≥</u> > ·= ≔ ۲ တ်

Pre-vocational readiness and support;

Medication Assisted Treatment

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	Medication Assisted Treatment a. The philosophical model of the program and the expected outcomes for program participants (i.e., harm reduction, abstinence, beginning of or maintaining individually defined recovery, employment readiness, relapse prevention, stabilization and treatment of those with co-occurring disorders); b. The schedule of activities and hours of operations:	program participants (i.e., , stabilization and treatme	harm reduction, abstinence, bent of those with co-occurring d	eginning of or maintaining isorders);	
		ve will be offered and/or π	nade available to those individu	ials who need them,	Case 1
	 Frow assessments will be conducted. Frow staff will be trained in the administration of substance use disorder services and technologies; G. How staff will be trained in the administration of substance use disorder services and activities addressing both mental health and substance. G. How services for individuals with co-occurring disorders who cannot be served in the regular program activities will be provided and/or referred for time-limited special. 	services and technologies nd will include services an e symptoms, problems, fu regular program activities	of substance use disorder services and technologies; disorders will be flexible and will include services and activities addressing both mental health and substance is based on, presenting the symptoms, problems, functioning, and capabilities of such individuals; to cannot be served in the regular program activities will be provided and/or referred for time-limited special	ental health and substance uch individuals; ed for time-limited special	.:16-cv-030
	integrated services that are co-occurring enhanced; i. How services will be coordinated with the substance abuse array of services including assuring or arranging for appropriate referrals and transitions; j. How the requirements in these service guidelines will be met; k. How services for individuals with HIV will be conducted to ensure the privacy of individuals.	ices including assuring or vacy of individuals.	arranging for appropriate refer	rals and transitions;)88-ELR
Service Access	The program must be in operation at least 5 hours per day Monday- Friday and a minimum of 3 hours per day on Saturdays.	nimum of 3 hours per day	on Saturdays.		[
Additional Medicaid Requirements	1. Medication Assisted Treatment services are unbundled and billed incrementally per service. As mentioned above MAT allows providers to select all services that will be offered in a MAT setting. Billable services and daily limits within the MAT Package are as follows:	per service. As mentione Package are as follows:	d above MAT allows providers	to select all services that	Oocume
	Service	Initial Authorization Units (90 Days)	Concurrent Authorization Units (365 Days)	Daily Maximum Billable Units	nt 44
	Behavioral Health Assessment & Service Planning Development	24	150	12	8-
	Individual Outpatient Services	12	96	1	73
	AD Support Services	100	96	4	
	Group Outpatient Services	180	730	4	Fil
	Medication Administration	08	150		ed
	Oploid Maintenance Psychiatric Treatment – (E&M)	00 9	001		11
	Nursing Services	24	96	4	/29
	Diagnostic Assessment	2	4	2	/23
	Family Outpatient Services	48	48	4	3
	Crisis Intervention	20	96	16	Р
	Peer Support	48	48	4	ag
	Interactive Complexity (as a modifier to Psychiatric Treatment, Diagnostic Assessment, Individual Counseling, and Group Counseling)	74	96	4	e 26
					7 of
Reporting and Billing Requirements	 The maximum number of units that can be billed differs depending on the individu Disease Orientation to Authorization Packages Section of this manual. 	ual service. Please refer to	depending on the individual service. Please refer to the table below or in the Mental Health and Addictive of this manual.	tal Health and Addictive	627

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Medication A	Į,	Medication Assisted Treatment
	2	2. Approved providers of this service may submit claims/encounters for the unbundled services listed in the package, up to the daily maximum amount for each
		service. Program expectations are that this model follows the content of this Service Guideline as well as the clearly defined service group elements.
	က	3. All applicable ASO, Adult Needs and Strength Assessment (ANSA), and DBHDD reporting requirements must be met.
	4.	4. The Opioid Maintenance code is used when there is the administration of methadone. Other federally approved MAT medications that are administered as part of
		the ordered IRP can be billed under the Medication Administration code (e.g. suboxone).
Documentation	1.	. Every admission and assessment must be documented.
Requirements	2	The complete and fully documented physical exam must be in the medical record; and
	က်	3. Progress notes must include written daily documentation of important occurrences; level of functioning; acquisition of skills necessary for recovery; progress on
		goals identified in the IRP including acknowledgement of a substance use disorder, progress toward recovery and use/abuse reduction and/or abstinence; use of
		drug screening results by staff; and evaluation of service effectiveness.
	4.	4. Daily attendance of each individual participating in the program must be documented showing the number of hours in attendance for billing purposes.
	5.	This service may be offered in conjunction with ACT or CSU for a limited time to manage a short-term crisis or to plan for an appropriate clinical continuity plan.
	9	6. When this service is used in conjunction with ACT or Crisis Residential services, documentation must demonstrate careful planning to maximize the effectiveness of
		this service as well as an appropriate reduction in service amounts of the service to be discontinued. Utilization of MAT services in conjunction with these services is
		subject to review by the Administrative Services Organization.
	7.	7. Individuals approved for this service must have a separate CID for DBHDD community services, which is a different ID number than that which is used by the
		DBHDD Central Registry.

MH Peer Sup	MH Peer Support Program													
Transaction	Code Detail	Code	Mod	роМ	Mod Mod	Mod	Rate	Code Detail	Code	Mod	Mod	Mod Mod	Mod	Rate
Code			1	2	3	4				1	2	3	4	
Peer Support	Practitioner Level 4, In-Clinic	H0038	HQ	U4	90		\$17.72	Practitioner Level 4, Out-of-Clinic	H0038	9 P	U4	U2		\$21.64
Services	Practitioner Level 5, In-Clinic	H0038	HQ	90	90		\$13.20	Practitioner Level 5, Out-of-Clinic	H0038	얼	OS	U2		\$16.12
Unit Value	1 hour							Utilization Criteria	TBD					
	This service provides structured	activities v	vithin a	peer su	upport c	enter t	hat promote	This service provides structured activities within a peer support center that promote socialization, recovery, wellness, self-advocacy, development of natural supports,	self-advoca	acy, de	velopme	ent of na	tural su	pports,
	and maintenance of community living skills. Activitie	living skills	. Activit	ties are	provide	od betw	een and an	es are provided between and among individuals who have common issues and needs, are consumer motivated,	ı issues an	nd need	ls, are c	onsume	r motive	ted,
	initiated and/or managed, and assist individuals in l	ssist individ	duals in	i living	as indep	nepuec	tly as possi	living as independently as possible. Activities must promote self-directed recovery by exploring individual purpose	ected reco	very by	/ explori	ing indivi	dual pu	pose
00:200	beyond the identified mental illne	ess, by exp	oloring p	lidissoc	ities of	recover	y, by tappir	beyond the identified mental illness, by exploring possibilities of recovery, by tapping into individual strengths related to illness self-management (including developing	o illness se	elf-man	agemer	nt (includ	ling dev	eloping
Definition	skills and resources and using to	ools related	to con	nmunic	ating re	covery	strengths, o	skills and resources and using tools related to communicating recovery strengths, communicating health needs/concerns, self-monitoring progress), by emphasizing	rns, self-m	onitorir	g progr	ress), by	empha	sizing
	hope and wellness, by helping ir	odividuals (develop	and w	ork tow	ard ach	ievement o	hope and wellness, by helping individuals develop and work toward achievement of specific personal recovery goals (which may include attaining meaningful	which may	include	e attaini	ing mear	ingful	
	employment if desired by the inc	dividual), aı	nd by a	ssisting	l individ	uals wi	th relapse p	employment if desired by the individual), and by assisting individuals with relapse prevention planning. A Consumer Peer Support Center may be a stand-alone center	eer Suppo	rt Cente	er may l	be a star	nd-alon	enter
	or housed as a "program" within	a larger a	gency a	and mus	st maint	ain ade	equate staff	or housed as a "program" within a larger agency and must maintain adequate staffing support to enable a safe, structured recovery environment in which individuals	ured recove	ery env	ironmer	nt in whic	ch indiv	duals
	can meet and provide mutual support.	ipport.												
	1. Individual must have a menta	al health is	sue whi	ch is th	e focus	of the	support; an	. Individual must have a mental health issue which is the focus of the support; and one or more of the following:						
	2. Individual requires and will be	enefit from	suppor	t of pee	∍r profe	ssional	s for the aco	2. Individual requires and will benefit from support of peer professionals for the acquisition of skills needed to manage symptoms and utilize community resources; or	symptom	s and u	ıtilize co	mmunity	resour	ces; or
Admission	3. Individual may need assistan	ice to deve	lop self	-advoc	acy skill	s to ac	hieve decre	3. Individual may need assistance to develop self-advocacy skills to achieve decreased dependency on the mental health system; or	ealth syste	m; or				
Criteria	4. Individual may need assistance and support to prepare for a successful work experience; or	ice and sup	port to	prepar	e for a 🤅	sacces	sful work ex	perience; or						
	5. Individual may need peer modeling to take increased responsibilities for his/her own recovery; or	deling to ta	ake incr	eased	respons	ibilities	for his/her	own recovery; or						
	6. Individual needs peer supports to develop or maintain daily living skills.	ts to devel	op or m	aintain	daily liv	ing ski	lls.							

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was an experience of supervision and dinical operations, and as long as they are not counted in individual to staff ratios for 2 different programs operating at the same washed and or activities and by staff who as Consequent who is not a consumer barrow store in the programs are not started and the staff and by staff who as Consequent who is not a consumer built is a guest timeter by peer leadership. Some consumer part and staff a
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	 v. Promote the concepts of employment and education to foster self-determination and career advancement. vi. Support each individual to "get a life" using community resources to replace the resources of the mental health system no longer needed. vii. Support each individual to fully integrate into accepting communities in the least intrusive environment that promote housing of his/her choice. viii. Actively seek ongoing consumer input into program and service content so as to meet each individual's needs and goals and foster the
	recovery process. b. A description of the particular consumer empowerment models utilized, types of activities offered, and typical daily activities and schedule. If offered, meals must be described as an adjunctive peer relationship building activity rather than as a central activity. c. A description of the staffing pattern, plans for staff who have or will have achieved Certified Peer Specialist and CPRP credentials, and how staff are
	f. A description of test-taking skills and strategies, assistance with study skills, information about training and testing opportunities to hear from and interact with consumers who are already certified, additional opportunities for consumer staff to participate in clinical team meetings at the request of
	an introduct, and the procedure for the Frogram Leader to request a team meeting. g. A description of the hours of operation, the staff assigned, and the types of services and activities provided for and by consumers as well as for families,
	parents, and/or guardians. h. A description of the program's decision-making processes including how consumers direct decision-making about both individual and program-wide
	i. A description of how individuals participating in the service at any given time are given the opportunity to participate in and make decisions about the activities that are conducted or services offered within the Peer Supports program, about the schedule of those activities and services, and other
	operational issues. j. A description of the space, furnishings, materials, supplies, transportation, and other resources available for individuals participating in the Peer Supports
	services. K. A description of the governing body and/or advisory structures indicating how this body/structure meets requirements for consumer leadership and cultural diversity.
	I. A description of how the plan for services and activities is modified or adjusted to meet the needs specified in each IRP.
	A description of now individual requests ve tools, technologies, worksheets, etc. can symptoms improvements etc with tra-
	 Providers must document services in accordance with the specifications for documentation requirements specified in Part II, Section III of the Provider Manual. The provider has several alternatives for documenting progress notes:
Documentation	a. Weekly progress notes must document the individual's progress relative to functioning and skills related to the person-centered goals identified in his/her IRP. This progress note aligns the weekly Peer Support-Group activities reported against the stated interventions on the individualized recovery plan, and
Requirements	documents progress toward goals. This progress note may be written by any practitioner who provided services over the course of that week; or b. If the agency's progress note protocol demands a detailed daily note which documents the progress above, this daily detail note can suffice to
	demonstrate functioning, skills, and progress related to goals and related to the content of the group intervention; or c. If the agency's progress note protocol demands a detailed hourly note which documents the progress above, this daily detail note can suffice to demonstrate functioning, skills, and progress related to goals and related to the content of the group intervention.

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MH Peer Support Program

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- While billed in increments, the Peer Support service is a program model. Daily time in/time out is tracked for while the person is present in the program, but due to time/in out not being required for each intervention, the time in/out may not correlate with the units billed as the time in/out will include breaks taken during the course of the program. However, the units noted on the log should be consistent with the units billed and, if noted, on the weekly progress note. If the units documented are not consistent, the most conservative number of units will be utilized. Other approaches may result in a billing discrepancy. რ
- for one unit of this service. For instance, if an individual participates in the program from 9-1:15 excluding a 30-minute break for lunch, his/her participating hours rounding policy included in this Provider Manual, and, specific to this service, the person served must have participated in at least 50% of the hour in order to bill Rounding is applied to the person's cumulative hours/day at the Peer program (excluding non-programmatic time). The provider shall follow the guidance in the are 3.75 hours. The rounding policy is applied to the .75 hour and the units billed for that day are 4 units. Practitioner type must still be addressed and so that 4 units must be adequately assigned to either a U4 or U5 practitioner type as reflected in the log for that day's activities. 4
 - service delivered. Should an individual leave the program or receive other services during the range of documented time in/time out for Peer Support hours, the A provider shall only record units in which the individual was actively engaged in services. Meals and breaks must not be included in the reporting of units of absence should be documented on the log. 5

MH Peer Sup	MH Peer Support Services - Individual	=												
Transaction	Code Detail	Code	Mod	Mod	M boM	Mod	Rate	Code Detail	Code	Mod	Mod	Mod	Mod R	Rate
Code			1	2	3 4					1	2	3	4	
	Practitioner Level 4, In-Clinic	H0038	U4	Oe		↔	\$20.30	Practitioner Level 4, Out-of-Clinic	H0038	U4	U2		↔	\$24.36
Door Clingary	Practitioner Level 5, In-Clinic	H0038	O5	90		↔	\$15.13	Practitioner Level 5, Out-of-Clinic	H0038	n2	U2		↔	\$18.15
Sopiese	Practitioner Level 4, Via							Practitioner Level 5, Via interactive						
odi vicas	interactive audio and video	H0038	GT	14 04		↔	\$20.30	audio and video telecommunication	H0038	GT	U5		↔	\$15.13
	telecommunication systems							systems						
Unit Value	15 minutes							Utilization Criteria	TBD					
	This service provides interventions	s which pr	omote s	ocializa	lion, reco	overy,	wellness,	This service provides interventions which promote socialization, recovery, wellness, self-advocacy, development of natural supports, and maintenance of community	al support	s, and n	nainten	ance of o	nnuuo	ity
	living skills. Activities are provided	between	and an	ong ind	ividuals	who ha	ave comm	living skills. Activities are provided between and among individuals who have common issues and needs, are individual motivated, initiated and/or managed, and	notivated,	initiate	d and/o	r manag	ed, and	
	assist individuals in living as indep	endently a	as possi	ble. Act	vities m	ust pro	mote self-	assist individuals in living as independently as possible. Activities must promote self-directed recovery by exploring individual purpose beyond the identified mental	dual purpo	se bey	ond the	identifie	d menta	_
Service	illness, by exploring possibilities or	f recovery	, by tap	oing into	individu	ıal stre	ngths rela	illness, by exploring possibilities of recovery, by tapping into individual strengths related to illness self-management (including developing skills and resources and	ding deve	loping s	skills an	d resour	ses and	
רפווווווווווווווווווווווווווווווווווווו	using tools related to communicating recovery strer	ng recove	ry stren	gths, co	mmunica	ating h	ealth nee	igths, communicating health needs/concerns, self-monitoring progress), by emphasizing hope and wellness, by	s), by emp	hasizin	g hope	and well	ness, by	
	helping individuals develop and we	ork toward	achiev	ement o	f specific	c persc	nal recov	helping individuals develop and work toward achievement of specific personal recovery goals (which may include attaining meaningful employment if desired by the	g meaning	yful emp	ploymer	nt if desir	ed by th	e e
	individual), and by assisting individ	duals with	relapse	preven	ion plani	ning. F	eer Supp	individual), and by assisting individuals with relapse prevention planning. Peer Supports must be provided by a Certified Peer Specialist.	Peer Spec	ialist.	•		•	
	1. Individual must have a mental health issue which is the focus of support; and one or more of the following:	nealth issu	le which	is the f	ocus of s	suppor	t; and on	e or more of the following:						
	2. Individual requires and will ben	efit from s	upport	of peer p	rofessio	nals fc	or the acqu	2. Individual requires and will benefit from support of peer professionals for the acquisition of skills needed to manage symptoms and utilize community resources; or	mptoms a	nd utiliz	ze comr	nunity re	sonrces	or
Admission	3. Individual may need assistance	to develo	p self-a	dvocac	skills to	achie	ve decrea	Individual may need assistance to develop self-advocacy skills to achieve decreased dependency on the mental health system; or	h system;	or				
Criteria	4. Individual may need assistance and support to prepare for a successful work experience; or	and supp	ort to p	repare f	or a succ	cessful	work exp	erience; or						
	5. Individual may need peer modeling to take increased responsibilities for his/her own recovery; or	eling to tak	ce increa	ased res	iliqisuod	ities fo	r his/her o	wn recovery; or						
	6. Individual needs peer supports to develop or maintain daily living skills.	to develo	p or ma	intain da	illy living	skills.								
Coto Sair sitas	1. Individual continues to meet admission criteria; and	mission c	riteria; a	pui										
Critoria Critoria	2. Progress notes document prog	ress relati	ve to gc	als ider	tified in t	the Ind	ividualize	2. Progress notes document progress relative to goals identified in the Individualized Recovery/Resiliency Plan, but treatment/recovery goals have not yet been	ment/recc	very go	als hav	e not yet	been	
Ollella	achieved.		1											

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MH Peer Su	MH Peer Support Services - Individual
Discharge Criteria	an has been estab overy Plan have be arge; or
Service	4. Iranster to another service/level is more clinically appropriate. Crisis Stabilization Unit (however those utilizing transitional heds within a Crisis Stabilization Unit may access this service)
Exclusions	סווסוס סומטווובמנוסו סוויר (ווסעיסיסי, נווססס מנווובווים נימוסוניסומו סכמס אינווווין מ סווסס סומטוובמנוסו סוויר (ווסעיסיסי, נווססס מנוווים מסויסים אינווווין מ סווסס סוומסס מנווים סכו יוסס מינוים אינויים אינ
Clinical Exclusions	 Individuals diagnosed with a Substance-Related Disorder and no other concurrent mental illness; or Individuals with the following conditions are excluded from admission unless there is clearly documented evidence of a psychiatric condition co-occurring with one of the following diagnoses: Developmental Disability, Autism, Neurocognitive Disorder, or Traumatic Brain Injury.
Required Components	 Peer Supports are provided in 1:1 CPS to person-served ratio. Individuals participating in the service at any given time must have the opportunity to participate in and make decisions about the person-centered interactions offered by the Certified Peer Specialist(s). Peer Supports cannot operate in isolation from the rest of the programs within the facility or affiliated organization. The CPS shall be empowered to convene multidisciplinary team meetings regarding a participating individual's needs and desires, and the Certified Peer Specialist must be allowed to participate as an equal practitioner partner with all staff in multidisciplinary team meetings. He/she also has the unique role as an advocate to the person-served, encouraging that person to steer goals and objectives in Individualized Recovery Planning.
Staffing Requirements	1 1 1 33 1
	4. The maximum cased and for S to persons served cannot be more train 1.30. 5. All CPSs providing this support must be able to articulate an understanding of recovery as defined by SAMHSA and psychiatric rehabilitation principles published by USPRA and must demonstrate the skills and ability to assist other individuals in their own recovery processes.
Clinical Operations	 Individuals receiving this service must have a qualifying diagnosis present in the medical record prior to the initiation of services. The diagnosis must be given by persons identified in O.C.G.A Practice Acts as qualified to provide a diagnosis. If a CPS serves as staff for a Peer Support Program and provides Peer Support-Individual, the agency has written work plans which establish the CPS's time allocation in a manner that is distinctly attributed to each program. CPSs providing this service must be treated as equal to any other staff of the facility or organization and must be provided equivalent opportunities for training (both mandated and offered) and benefits competitive and comparable to other staff based on experience and skill level. Individuals should set their own individualized goals and assess their own skills and resources related to goal attainment. Goals are set by exploring strengths and needs in the individual's living, learning, social, and working environments. Goal attainment should be supported through a myriad of approaches (e.g. coaching approaches, assistance via technology, etc.). Each service intervention is provided only in a 1:1 ratio between a CPS and a person served. Each individual must be provided the opportunity for peer assistance in the development and acquisition of needed skills and resources necessary to achieve stated goals. The program must have a Peer Supports Organizational Plan addressing the following: A service philosophy reflecting recovery principles as articulated by the Georgia Consumer Council, August 1, 2001. This philosophy must be actively incorporated into all services and activities and:
	iii. Promote information about mental illness and coping skills.

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 iv. Promote peer-to-peer training of individual skills, social skills, community resources, and group and individual advocacy. v. Promote the concepts of employment and education to foster self-determination and career advancement. vi. Support each individual to "get a life" using community resources to replace the resources of the mental health system no longer needed. vii. Support each individual to fully integrate into accepting communities in the least intrusive environment that promote housing of his/her choice. viiii. Actively seek ongoing consumer input into program and service content so as to meet each individual's needs and foster the recovery process. b. A description of the particular consumer empowerment models utilized and types of recovery-support activities offered which are reflective of that model. 		diversity. I. A description of how the plan for services and activities is modified or adjusted to meet the needs specified in each IRP. I. A description of how the plan for services and activities is modified or adjusted to meet the needs specified in each IRP. J. A description of how individual requests for discharge and change in services or service intensity are handled. 8. Assistive tools, technologies, worksheets, etc. can be used by the CPS to work with the served individual to improve his/her communication about treatment, symptoms, improvements, etc. with treating behavioral health and medical practitioners.	To promote access, providers may use Telemedicine as a tool to provide direct interventions to individuals for whom English is not their first language. Examples of this include: • the use of one-to-one service intervention via Telemedicine, connecting the individual to a practitioner who speaks the individual's language versus use of interpreters; and/or • the use of an interpreter via Telemedicine to support the practitioner in delivering the identified service.	Telemedicine may only be utilized when delivering this service to an individual for whom English is not their first language. The individual must consent to the use of this modality. This consent should be documented in the individual's record. The use of telemedicine should he driven by the practitioner's/agency's convenience or preference. Providers must document services in accordance with the specifications for documentation requirements specified in Part II, Section III of the Provider Manual.	When Telemedicine technology is utilized for the provision of this service in accordance with the allowance in the Service Accessibility section of this definition, the code cited in the Code Detail above with the appropriate GT modifier shall be utilized in documentation and claims submission. Is a Mod
MH Peer S			Service Accessibility	Documentation Requirements	Billing & Reporting Requirements Mobile Crisis Transaction Code

Mobile Crisi	S												
Transaction	Code Detail	Code	Mod	Mod	Mod	Mod	Rate	Code Detail	Code	Mod	Mod	Mod	Mod
Code			_	7	က	4				_	7	က	4

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The Mobile Crisis Response Service (MCRS) provides community-based face-to-face rapid response to individuals in an active state of crisis. This service operates 24 hours a day, seven days a week. MCRS offers short-term, behavioral health, intellectual/developmental disability, and/or Autism Spectrum Disorder (ASD) crisis response for individuals in need of crisis assessment, intervention, and referral services within their community. This service is unique in that it provides in-person intervention to persons in their community who may be in crisis. MCRS may be provided in community settings including, but not limited to homes, residential settings, other treatment/support settings, schools, hospital emergency departments, jails, and social service settings. Interventions include a brief, situational assessment; verbal and or behavioral interventions to de-escalate the crisis; assistance in immediate crisis resolution; mobilization of natural support systems; and referral to alternate services at the appropriate level.	MCRS includes in-field crisis assessment, crisis de-escalation, rapid assessment of strengths, problems and needs; psychoeducation, brief behavioral support and intervention; and referral to appropriate services and supports. MCRS functions to provide a short-term linkage and referral between persons in crisis and the appropriate/additional behavioral health and/or IDD services and supports, while reducing the rate of hospitalization, incarceration, out of home placement and unnecessary emergency room visits. This service includes post crisis follow-up to ensure linkage with recommended services. The service is available to individuals with behavioral health diagnoses and/or intellectual and/or developmental disabilities, including Autism Spectrum Disorder (ASD),	aged four (4) years and above who meet the following eligibility criteria: 1. The individual is experiencing an acute Behavioral Health, Intellectual/Developmental Disability, ASD, and or Co-occurring crisis (inclusive of two (2) or more of these conditions); and these conditions); and 2. The individual and/or family/caregiver lacks the skills necessary to cope with the immediate crisis and there exists no other available, appropriate community	 supports to meet the needs of the person; and The individual needs immediate care, evaluation, stabilization or treatment due to the crisis as evidenced by: A substantial risk of harm to self or others by the individual; and/or The individual is engaging in behaviors presenting with serious potential legal or safety consequences; or The individual is engaging in behaviors presenting with serious potential legal or safety consequences; or Screening provided by the Georgia Crisis and Access Line (GCAL) indicates the presence of a behavioral health, an intellectual/developmental disability, and/or 	.5. N/A	 The acute presentation of the crisis situation is resolved; Appropriate referral(s) and service engagement/s to stabilize the crisis situation are completed; Recommendations for ongoing services, supports or linkages have been documented; and Post-crisis follow-up has been completed within 1-3 days of crisis contact. 	Individuals in the following settings are excluded from MCRS dispatch; Crisis Stabilization Units (CSU), Behavioral Health Crisis Centers (BHCC), CRR-I, psychiatric hospital (state or private); state prisons; youth detention center; and regional youth detention center. 1. All persons receiving MCRS must have present indications of a behavioral health disorder, an Intellectual/Developmental Disability and/or ASD. 2. MCRS shall not be dispatched for individuals presenting solely with a need for Substance Use Disorder (SUD) intervention. 3. MCRS shall not be dispatched in response to a medical emergency.	 A mobile crisis team responder offering any diagnostic impressions must be a person identified in O.C.G.A. Practice Acts as qualified to provide a diagnosis and who possess training and experience in behavioral health and intellectual/developmental disability assessment. The Licensed clinician on the Mobile Crisis Team is to provide oversight and clinical supervision to the operation of the team and is responsible for ensuring that the appropriate team members are dispatched or are available for consultation based on the clinical data provided by the Georgia Crisis and Access Line (GCAL).
Mobile Crisis Response Service Service Definition			Admission Criteria	Continuing Stay Criteria	Discharge Criteria	Service Exclusions Clinical Exclusions	Required

Mobile Crisis

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Mobile Crisis

- The Mobile Crisis Team is to:
- Respond and arrive on site within 59 minutes of the dispatch by GCAL; and.
- Address the crisis situation to mitigate any risk to the health and safety of the individual and/or others; and
- Consult with medical professionals, when needed, to assess potential medical causes that might be contributing to the crisis prior to recommending any intensive crisis supports involving behavioral interventions.
- include interviews with the individual, care providers and/or family members, observation of the current environment, and review of behavior and individual support The Mobile Crisis Team members are responsible for completing comprehensive assessment(s) of the current crisis situation. This assessment process shall plans if available. The licensed professional or BCBA on the team is responsible for ensuring that the assessment process is thorough and complete. 4.
 - individual/family/caregivers in a therapeutic plan that fosters a return to pre-crisis level of functioning and connect or reconnect the individual to treatment services A crisis plan will be developed to help manage, prevent, or reduce the frequency of future crises occurring. When available, an individual's existing crisis plan should be utilized by the MCRS team when it is appropriate to the presenting situation. When a crisis plan does not exist, MCRS will engage the and other community resources. 5
 - Also, when available and offered by the individual, a Wellness Recovery Action Plan (WRAP) shall be utilized by MCRS to support the individual's
- When available, an individual's behavior support plan shall be utilized by MCRS during the assessment process.
- All interventions shall be offered in a clinically appropriate manner that respects the preferences of the individual in crisis while recognizing the primary need to <u>ဖ</u>
- Reasonable and relatively simple environmental modifications that do not require continuing programmatic efforts are considered before intensive crisis supports and/or a behavior plan is recommended or implemented.
- When applicable and accessible, community supports, natural supports, and external helping networks should be utilized for crisis planning to assist in crisis ∞.
 - e.g., Provider Agencies Families/Caregivers/ Guardians, Support Coordination Agencies, known Care Coordinators and/or Regional Field Office I&E Teams as When the Mobile Crisis Team makes a disposition, the licensed clinician or BCBA communicates all recommendations within 24 hours to all applicable parties <u>ග</u>
- The MCRS shall comply with the current GCAL process for dispatch of mobile crisis, including non-refusal of calls or dispatch.
- 11. When the Mobile Crisis Team completes services, the licensed clinician or BCBA on the team completes a written summary that shall:
- a. Minimally include:
- Description of precipitating events
- Assessment and Interventions provided
- Diagnosis or diagnostic impressions
 - Response to interventions
- Crisis plan
- Recommendations for continued interventions
- Linkage and Referral for additional supports (if applicable); and
- b. Be completed and documented within a 24-hour period after a disposition has been determined.
- representative/parent/guardian. Exceptions to this requirement are for persons for whom the mobile crisis intervention results in placement in a hospital, CSU, Within 24 hours of completion of the MCRS intervention a follow-up phone call is made and documented to individuals served or their BHCC, intensive in-home IDD supports, or an IDD crisis home.
- The MCRS provider must develop policies and procedures consistent with DBHDD policies for referral and engagement with Crisis Stabilization Units (CSUs) Behavioral Health Crisis Centers (BHCCs), Crisis Respite Homes and In-Home I/DD Supports; (i.e., staffing, eligibility, service delivery, GCAL interface) 3.
 - Additionally, the MCRS provider must develop policies and procedures that include criteria for determination of the need for higher levels of care, indicators for 4.

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All mobile crisis service response times for arrival at the site of the crisis must be less than 59 minutes of dispatch by the GCAL. Services are available 24-hours a day, 7 days a week, and include face-to-face contact offered in eligible settings (e.g., home/community, school, jail, emergency room). MCRS may not be provided in an Institution for Mental Diseases (IMD, e.g., treatment units for state or private psychiatric hospital, psychiatric residential treatment facility or crisis stabilization program), nursing homes, youth development center (YDC), or State Prisons. Telemedicine is the use of medical information exchanged from one site to another via electronic communications to improve a patient's health. Electronic communication between the patient, and the physician or practitioner at the distant site. Telemedicine is never to be utilized as the primary means of delivery of MCRS services. Providers must document services in accordance with the specifications for documentation requirements specified in Part II, Section IV of the Provider Manual and in keeping with this section 6. Documentation will include the following; a. Calls received; Referring source; individual, agency,		m. Contact information for follow-up. n. Follow-up contact: Each MCRS shall provide monthly outcomes data as defined by the DBHDD. All other applicable DBHDD reporting requirements must be followed. Where there are individuals covered by Georgia CMOs and the specific CMO is identified, the MCRS provider will report the MCRS intervention to the CMO.	Code Mod Mod Mod Rate 1 2 3 4 17.40 U4 U6 17.40
All mobile crisis service response times for arrival at the site of the crisis must be less than 59 minutes of dispatch by the GCAL Services are available 24-hours a day, 7 days a week, and include face-to-face contact offered in eligible settings (e.g., home/croom). MCRS may not be provided in an Institution for Mental Diseases (IMD, e.g., treatment units for state or private psychiatric hospi facility or crisis stabilization program), nursing homes, youth development center (YDC), or State Prisons. Telemedicine is the use of medical information exchanged from one site to another via electronic communications to improve a communication between the patient, and the physician or practitioner at the distant site. Telemedicine is never to be delivery of MCRS services. Providers must document services in accordance with the specifications for documentation requirements specified in Part II, Sein Reeping with this section G. Documentation will include the following; a. Calls received; b. Referring source; individual, agency,		JD. IMO is identified, the MCRS pr	Code Detail H0020
the crisis r de face-to s (IMD, e.g. velopment one site t one pracian or pracian or pracian fications fi	ints made	rthe DBHI owed. specific C	Rate 33.40
ne site of the site of the site of the specific the speci	ppointme	lefined by ust be foll s and the	Mod 4
rrival at the same and the same are the same and the same and the same and the same with a same with the same with the same and the same and the same same and the same same and the same same same and the same same and the same same and the same same same same same same same sam	rovided/a	data as c ments mi gia CMO:	Wod 3
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ilable 24-liable 24-liable 24-liable 24-liablization he use of neans the unication services ocument sits section its section urce; indiverse indiv	Ived call, of action of respon of respon all on-site pletion of interver of or diagon of disk commen assessments.	mation for materials and materials for m	
All mobile crisis service response times for arrival at the site of the crisi Services are available 24-hours a day, 7 days a week, and include face room). MCRS may not be provided in an Institution for Mental Diseases (IMD, facility or crisis stabilization program), nursing homes, youth developm. Telemedicine is the use of medical information exchanged from one sit communication means the use of interactive telecommunications equipinteractive communication between the patient, and the physician or prodelivery of MCRS services. Providers must document services in accordance with the specification in keeping with this section G. Documentation will include the following: a. Calls received; b. Referring source; individual, agency,	 c. Ilme of received call, d. Specific plan of action to address need; e. Composition of responders f. Time of arrival on-site g. Time of completion of assessment h. Description of intervention, i. Diagnosis and or diagnostic impressions j. Documentation of disposition, linkages provided/appointments made k. Behavioral recommendations provided; l. Provision of assessment upon Release of Information 	m. Contact information for follow-up n. Follow-up contact. Each MCRS shall provide monthly outcomes data as defined by the DBHDD. All other applicable DBHDD reporting requirements must be followed. Where there are individuals covered by Georgia CMOs and the specific CMC	ance Treatment de Detail 020

		delivery of MCRS services
	<u></u>	Providers must document services in accordance with the specifications for documentation requirements specified in Part II, Section IV of the Provider Manual and
		in keeping with this section G. Documentation will include the following;
		a. Calls received;
		b. Referring source; individual, agency,
		c. Time of received call,
		d. Specific plan of action to address need;
		e. Composition of responders
		f. Time of arrival on-site
 Documentation Requirements		g. Time of completion of assessment
		h. Description of intervention,
		i. Diagnosis and or diagnostic impressions
		j. Documentation of disposition, linkages provided/appointments made
		k. Behavioral recommendations provided;
		I. Provision of assessment upon Release of Information
		m. Contact information for follow-up
		n. Follow-up contact.
	2	Each MCRS shall provide monthly outcomes data as defined by the DBHDD.
Billing &	1	
Reporting	2	Where there are individuals covered by Georgia CMOs and the specific CMO is identified, the MCRS provider will report the MCRS intervention to the CMO.
 Requirements		

MCRS must be available by staff skilled in crisis intervention 24 hours a day, 7 days a week with emergency response coverage, including psychiatric, medical and

All mobile crisis service response times for arrival at the site of the crisis must be less than 59 minutes of dispatch by the GCAL

nursing consultation services as required

4.

Accessibility Service

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0	pioid Maint	tenance Treatment													
Tr	ansaction	Code Detail	Code	Mod	Mod	Mod	Mod	Rate	Code Detail	Code	Mod	Mod	Mod	Mod	Rate
S	Sode			1	2	3	4				1	2	3	4	
		H0020	U2	90				33.40	H0020	U4	90				17.40

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m rd}$ Quarter Provider Manual for Community Behavioral Health Providers (January 1, 2023)

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Opioid Maint	Opioid Maintenance Treatment				
Alcohol and/or Drug Services; Methadone Administration	Н0020	N3	90	25.39	
Unit Value	1 encounter			Utilization Criteria TBD	
Service Definition	An organized, usually ambulatory, substance use dis as dosage, level of care, length of service or frequen psychosocial treatment sessions and medication visi and procedures, including admission, discharge and 291. Length of service varies with the severity of the or LAAM is designed to address the individual's goal use. To accomplish such change, the Individualized undermine the goals of recovery. The Individualized education specific to addiction recovery (including education specific to addiction recovery).	ulatory, singth of se ssions and admission es with the dress the dress the hange, the overy. The overy.	ubstance ervice or d medica n, dischal e severit individus e Individus e Individus	corder treatment service for in cy of visits) is determined by the (often occurring on a daily the continued service criteria stip individual's illness, as well as to achieve changes in his or Recovery/Resiliency Plan mu Recovery/Resiliency Plan shout human immuniciality.	is. The nature of the services provided (such ervices always includes scheduled ses function under a defined set of policies e federal regulations at FDA 21 CFR Part linue treatment. Treatment with methadone ion of illicit opiate and other alcohol or drug behavioral issues that have the potential to resource coordination, and personal health and sexually transmitted diseases (STD)).
Admission Criteria Continuing Stay Criteria Discharge	Must meet criteria establish Division) and the Food and	ned by the	e Georgia ministrati	Must meet criteria established by the Georgia Regulatory body for opioid administration programs (Department of Community Health, Healthcare Facilities Regulation Division) and the Food and Drug Administration's guidelines for this service.	ity Health, Healthcare Facilities Regulation
Required Components	 This service must be licensed by DCH/HFR undel Must meet and follow criteria established by the G Regulation Division) and the Food and Drug Adm 	ensed by iteria esta d the Food	DCH/HF ablished I d and Dr	1FR under the Rules and Regulations for Drug Abuse Treatment Programs, 290-4-2. d by the Georgia regulatory body for opioid administration programs (Department of Community Health, Healthcare Facilities Drug Administration's guidelines for this service.	-4-2. rt of Community Health, Healthcare Facilities
Additional Medicaid Requirements	Tier I and II providers who are approved to bill Medic	are appro	ved to bi	bill Medication Administration may bill H0020 for Medicaid recipients who receive this service.	e this service.
Documentation Requirements	If medically necessary for the individual, the Individu health education specific to substance use disorder transmitted diseases [STD]).	the individ substant ().	lual, the ce use di	If medically necessary for the individual, the Individualized Recovery/Resiliency Plan should also include individualized treatment, resource coordination, and personal health education specific to substance use disorder recovery (including education about human immunodeficiency virus [HIV], tuberculosis [TB], and sexually transmitted diseases [STD]).	itment, resource coordination, and personal VJ, tuberculosis [TB], and sexually

Peer Suppor	Peer Support, Wellness and Respite Center - Respite				
Transaction Code	Code Detail	Code	Mod 1	Mod 2	
Rehabilitation Program	Peer Supported Daily Wellness Activities	H2001	MH	n	
Unit Value	1 day	Maximum Daily Units	1 unit	1 unit Maximum Utilization 7 units	
	Peer Support, Wellness and Respite Center - Respite services are a self-directed, trauma-informed, and recovery-oriented alternative to traditional clinical crisis	ma-informed, and recovery-oriented	l alternat	ive to traditional clinical crisis	
Service	services; and support peers in seeing crisis as an opportunity for learning and growth. These services are a combination of an overnight stay (up to 7 consecutive	These services are a combination or	f an ovel	might stay (up to 7 consecutive	
Definition	nights) with Intentional Peer Support as a key recovery approach during that stay. The PSWRC Respite experience is offered as a safe environment in which an	PSWRC Respite experience is offer	red as a	safe environment in which an	
	individual can be supported to accomplish the individualized expectations set forth in the proactive interviewing process (cited below).	ne proactive interviewing process (ci	ited belo	w).	

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Admission Criteria 2 3 Continuing Stay T Criteria 1	1. Individuals with a behavioral health condition who are experiencing an emotional, mental, and/or psychiatric crisis and have previously completed a pre-crisis, proactive interview is an interactive dialogue between a center peer staff and a peer who may choose this service in the future. The	
	_	
	 Individuals must be 18 years or older. Individuals must be capable of basic self-care during their stay. 	Cas
	The individual continues to articulate a need for the respite up through the 7th night.	se 1:
	1. The individual indicates a desire to leave the support;	16
	2. The individual fails to meet the Participation and Respite Guidelines expectations that are mutually agreed upon during the interview process.	-CV
Service 2 Exclusions 3	 The PSWRC does not provide medical services. The PSWRC does not accept individuals who are registered sex offenders. The PSWRC does not provide crisis, clinical or case management services. 	·-03088
		3-EI
.v m	 Each site will have a minimum of 3 bedrooms available for individuals in need of this service. Each site will have a gathering room for a group of 8-12 individuals as well as additional space for other groups to coincide. 	_R
4		
	5. Freedom to come and go is promoted in order to work, attend school, appointments or other activities.	Doc
Components 6	The P	cur
		ment 44
	d. A bathroom to be shared with center guests.	18-
Staffing 2 Requirements	 A PSWRC has a full-time Director who is a Certified Peer Specialist. The number of remaining staff are defined in contracts but are required to be specially trained Certified Peer Specialists who have participated in targeted areas of training such as Intentional Peer Support, CPR/First Aid, etc. 	-73 F
1	 This service is operational 24 hours a day, 7 days a week. Respite guests are able to access: 	iled
	a. Daily Peer Support and Wellness activities provided by the Center,	11
Service Accessibility	 b. A washer & dryer to wash linens and clothing, c. A kitchen to cook food (food provided by center and prepared by respite guest), 	/29/2
	On-site computers, A locked box to store medications that individua	23 F
Documentation Ir	nals	age
	 Place of Service Code 99 will be used for all claims/encounter submissions to the ASO. Span billing may occur for this service within a single month, meaning the start and end date are not the same on a given service claim line. 	280 of

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	Mod Mod Mod Mod 1 2 3 4	MH	1 unit	ed recovery. During scheduled hours,																										who have participated in targeted areas of	ired as staff with the performance		
	Code	H2001	Maximum Daily Units	ess and toward a life of self-directer support topics which may occur a															in and choose to participate.								erson to the supports available.	Activities.		trained Certified Peer Specialists v	ual with lived experience may be h		and engagement.
Peer Support, Wellness and Respite Center - Daily Wellness	Code Detail	Peer Supported Daily Wellness Activities	1 day	Daily Wellness Activities are holistic in nature, support people with moving beyond their illness and toward a life of self-directed recovery. During scheduled hours, PSWRC Peer Daily Wellness Activities may include but are not limited to the following peer support tonics which may occur at the community.	1. Employment Supports:	2. Basic Finance/Financial Planning;	3. Independent Housing;			6. Double Trouble in Recovery;		8. Community Outreach and Connections;	10. Cooking and Nutrition;			Physical Activities, such as yoga;		15. Social Group Activities.	1. Wellness activities shall be available to respite guests as well as individuals who walk-in and choose to participate.	2. Individuals must be rapped of basic self-care during their stay.	ne individual continues to attend and participate.	1. The individual indicates a desire to leave the support;	2. The individual fails to meet the Participation Guidelines.		2. The PSWRC does not accept individuals who are registered sex offenders.		2. During a first encounter, the PSWRC staff provide a tour for individuals to orient the person to the supports available.		1. A PSWRC has a full-time Director who is a Certified Peer Specialist.	2. The number of remaining staff are defined in contracts but are required to be specially trained Certified Peer Specialists who have participated in targeted areas of	training such as Intentional Peer Support, CPR/First Aid, etc. (in rural areas, an individual with lived experience may be hired as staff with the performance	The DRIVID Walk in Containing and James 2 days a map from 10:00 cm to 6:00 cm	I ne PSWKC Walk-in Center is available 7 days a week from 10:00 am to 6:00 pm. 1. This recovery support is provided on a drop-in basis promoting immediate availability and engagement.
Peer Supp	Transaction Code	Rehabilitation Program	Unit Value							Sprvice	Definition								Admission	Criteria	Continuing Stay Criteria	Discharge	Criteria	Service	Exclusions		Required	Components		Staffing	Requirements		Service Accessibility

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Peer Suppor	Peer Support, Wellness and Respite Center - Daily Wellness	
	2. Structured wellness activities are offered intermittently during these hours of operation.	
	3. Peer support is available at any point during the open hours.	
Documentation	1. Any individual who signs-in between the hours of 10:00 am to 6:00 pm will be considered supported as a participant for that day.	
Requirements	2. Sign-in sheets will be maintained by the PSWRC.	-
Billing &	1. Visitors that drop-in who do not self-identify as having lived experience are not to be included as a daily participant.	
Reporting	2. Place of Service Code 99 will be used for all claims/encounter submissions to the ASO.	
Requirements		

Peer Suppor	Peer Support, Wellness and Respite Center - Warm Line						
Transaction Code	Code Detail	Code	Mod 1	Mod 2	Mod 3	Mod 4	
Behavioral Health Hotline Services	Peer Supported Warm Line	H0030					
Unit Value	1 contact	Maximum Daily Units	1 unit				
Service Definition	Warm line services afford individuals access to 24/7 peer support and non-urgent crisis support over the telephone. In addition to peer support, callers can receive information about community and natural supports. Warm transfers of calls can be made to GCAL when appropriate.	rt over the telephone. In addition CAL when appropriate.	to peer	support,	callers c	an receive	
Admission Criteria	Anyone with a behavioral health condition that calls the warm line for the purposes of peer support.	pport.					
Staffing Requirements	 A PSWRC has a full-time Director who is a Certified Peer Specialist. The number of remaining staff are defined in contracts but are required to be specially trained Certified Peer Specialists who have participated in targeted areas of training such as Intentional Peer Support, CPR/First Aid, etc. (in rural areas, an individual with lived experience may be hired as staff with the performance expectation that the CPS credential will be achieved). 	red Certified Peer Specialists whα vith lived experience may be hire	o have p d as staf	articipate f with the	ed in targ	eted areas ance	of
Service Accessibility	24 hours, 7 days a week.						
Documentation Requirements	 Calls are documented by the PSWRC staff including time of call and CPS who provided support. Calls which are not indicated as Peer Support calls (wrong numbers, abandoned calls, etc.) are not documented as Warm-line contacts. 	pport.) are not documented as Warm-li	ine conta	acts.			
Billing & Reporting Requirements	 If an individual calls more than once per day, he/she is reported as having received one Warm Line support for that day. Place of Service Code 99 will be used for all claims/encounter submissions to the ASO. 	arm Line support for that day.					

	Rate	\$5.41
	Mod 4	
	Mod 3	U7
	Mod 2	U4
	Mod 1	HQ
	Code	H0025
	Code Detail	Practitioner Level 4, Group, Out-of-clinic
	Rate	\$4.43
	Mod 4	
	Mod 3	90
	Mod 2	U4
d	Mod 1	НД
s - Grou	Code	H0025
eer Support Whole Health & Wellness - Group	Code Detail	Practitioner Level 4, Group, In-clinic
Peer Sup	Transaction Code	

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H0025	TBD	icipants vingful modirector of	ated to en sical; ass	rt the indi yate the h ss with th to practic	g and sup daily acti increment ients for v salth com their over
Practitioner Level 5, Group, Out-of-clinic	Utilization Criteria	Definition of Service: This is a group service in which the Whole Health & Wellness Coach (CPS-WH) assists participants with setting personal expectations, introducing health objectives as an approach to accomplishing overall life goals, helping identify personal and meaningful motivation, and health/wellness self-management. The individuals served should be supported by the CPS-WH and the members of the group to be the director of his/her health through identifying incremental and measurable steps/objectives that make sense to the person, considering these successes as a benchmark for future success.	neatin engagement and neatin management, supporting the individual in overcoming fears and anxiety related to engaging with health care providers, exploring the multiple choices for health care providers and exploring the multiple choices for health health practitioners including, at a minimum, participating in an annual physical; assisting the individual in the work of finding a compatible primary physician who is trusted; among other engagement activities.	Another major objective is promoting access to health supports. This is accomplished by using technology to support the individual's goals; providing materials which assist in structuring the individual's path to prevention, healthcare, and wellness; partnering with the person to navigate the health care system; assisting the person in developing his/her own natural support network which will promote that individual's wellness goals; creating solutions with the person to overcome barriers which prevent healthcare engagement (e.g. transportation, food stamps, shelter, medications, safe environments in which to practice healthy choices, etc.); and linking the individual with other health and wellness resources (physical activity, fitness, healthy/nutritional food).	The Whole Health & Wellness Coach (CPS-WH) and supporting nurse also provide the following health skill-building and supports: Share basic health information which is pertinent to the individual's personal health; Promote awareness regarding health indicators; Assist in understanding the idea of whole health and the role of health screening; Assist in understanding the idea of whole health and the role of health screening; Make available wellness tools (e.g., relaxation response, positive imaging, education, wellness toolboxes, daily action plans, stress management, etc.) to support the individual's identified health goals; By Provide concrete examples of basic health changes and work with the group members in the selection of incremental health goals; Carbinocetie examples of basic health changes and work with the group members in the selection of incremental health goals; Provide concrete examples of basic health obasics healthy lifestyle choices; Promote and offer healthy environments and skills-development to assist in modifying own living environments for wellness; Promote and offer healthy environments and skills-development to assist in health settings, etc.); Support group members as they practice creating healthy habits, personal self-care, self-advocacy and health picture; Support group members to identify and understand how his/her family history, genetics, etc. contribute to their overall health picture; Support group members in understand ing medications and related health scales, nearthy choices, nutrition, healthy meal preparation, teaching early warning signs/symptoms which indicate need for health intervention, etc.
\$3.30		liness Coach, helping ide the member onsidering the coach of the coach	is of the servin overcomit imum, particus.	ts. This is accomplished by using technocare, and wellness; partnering with the pomote that individual's wellness goals; crups, shelter, medications, safe environactivity, fitness, healthy/nutritional food).	le Health & Wellness Coach (CPS-WH) and supporting nurse also provide the following hea Share basic health information which is pertinent to the individual's personal health; Promote awareness regarding health indicators; Assist in understanding the idea of whole health and the role of health screening; Support behavior changes for health improvement; Make available wellness tools (e.g., relaxation response, positive imaging, education, welln support the individual's identified health goals; Prowide concrete examples of basic health changes and work with the group members in th Teach/model/demonstrate skills such as nutrition, physical fitness, healthy lifestyle choices; Promote and offer healthy environments and skills-development to assist in modifying own Support group members as they practice creating healthy habits, personal self-care, self-addisclosing history, discussing prescribed medications, asking questions in health settings, e Support group members to identify and understand how his/her family history, genetics, etc Support group members in understanding medication and related health concerns; and Promote health skills, considering fitness, healthy choices, nutrition, healthy meal preparatic health intervention, etc.
		alth & Wellife goals S-WH and person, or	y objective individual 3, at a min nt activitie	is accomp d wellness at individu elter, med fitness, he	e also pro idual's pe idual's pe of health kitness, he itness, hes abits, pers g questior her family alated hea
90		hole He g overal the CP? e to the	ting the including	ts. This care, an amote the mps, she activity,	ing nurs the indii the role and wo hysical f levelopr salthy h, s, askin, how his, nn and re
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ellness		s is a grouss as an a sas an a sala served le steps/c	ealth mans ses for he agement an who is	promoting ividual's pural suppural suppural suppural suppural (e.g. and wellt	sess Coace h informations regard inding the changes to changes to changes to changes to change in the changes on strate in the change in the c
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Healt		of Serv health on The land me	agemer ne multij ;; promo primary	ajor obje ructuring his/her althcare vith othe	e Health & Wellness Co Share basic health information of the Sasist in understanding Support behavior chang Make available wellness support the individual's Prowide concrete exami Teach/model/demonstramont group member disclosing history, discusupport group member Support group member Promote health intervention, etc.
t Whole Health & Wellnes	15 minutes	Definition of Service: This is a group service in which the W introducing health objectives as an approach to accomplishin management. The individuals served should be supported by incremental and measurable steps/objectives that make sens	neating engagement and neating management for the individual are key objectives exploring the multiple choices for health engagement; supporting the individual in procedures; promoting engagement with health practitioners including, at a mining compatible primary physician who is trusted; among other engagement activities.	Another major objective is promoting access to health suppor assist in structuring the individual's path to prevention, health developing his/her own natural support network which will proprevent healthcare engagement (e.g. transportation, food staindividual with other health and wellness resources (physical	The Whole 1.0 Signature 1.1. Signatu
Peer Support Whole Health & Wellness - Group Health and Wellness Supports (Behavioral Health Practitioner Level 5, Group, In-clinic Services with Tanget Population to Affect Knowledge, Attitude	and/or Benavior) Unit Value				Service Definition

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Peer Suppor	Peer Support Whole Health & Wellness - Group	
	Specific interventions may also include supporting the individual group members in being able to have conversations with various providers to access health support and treatment and assisting individuals in gaining confidence in asserting their personal health concerns and questions, while also assisting the person in building and maintaining self-management skills. Health should be discussed as a process instead of a destination.	
	Assistance will be provided to group members to facilitate active participation in the development of Individualized Recovery Plan (IRP) health goals which may include but not be limited to attention to dental health, healthy weight management, cardiac health/hypertension, vision care, substance use disorders (including smoking cessation), vascular health, diabetes, pulmonary, nutrition, sleep disorders, stress management, reproductive health, human sexuality, and other health areas.	Case 1:
	These interventions are necessarily collaborative: partnering with health providers and partnering with individuals served in dialogues with other community partners and supporters to reinforce and promote healthy choices. The Whole Health & Wellness Coach (CPS-WH) must also be partnered with the identified supporting nurse and other licensed health practitioners within the organization to access additional health support provided by the organization or to facilitate health referral and access to medical supports external to the organization providing this service.	16-cv-030
	The interventions are based upon respectful and honest dialogue supported by motivational coaching. The approach is strengths-based: sharing positive perspectives and outcomes about managing one's own health, what health looks like when the person gets there (visioning), assisting a person with re-visioning his/her self-perception (not as "disabled"), assisting the person in recognizing his/her own strengths as a basis for motivation, and identifying capabilities and opportunities upon which to build enhanced health and wellness. The peer-to-peers basis for the service allows the sharing of personal experience, including modeling wellness and	88-ELR
	mutual respect and support that is also respectful of the individualized process and journey of recovery. This equality partnership between the supported individual and the Whole Health & Wellness Coach (CPS-WH) should serve as a model for the individual as he/she then engages in other health relationships with health services practitioners. As such the identified nurse member of the team is in a supporting role to the Whole Health & Wellness Coach (CPS).	Docum
	A mind/body/spirit approach is essential to address the person's whole health. Throughout the provision of these services the practitioner addresses and accommodates an individual's unique sense of culture, spirituality, and self-discovery, assisting individuals in understanding shared-decision making, and in building a relationship of mutual trust with health professionals.	nent 448
	Individual must have two co-existing serious health condition of substance use disorde	3-73
Admission Criteria	 Individual requires and will benefit from support of Whole Health & Wellness Coaches (CPS-WHs) and from a group model for the acquisition of skills needed to manage health symptoms and utilize/engage community health resources; or Individual may need assistance to develop self-advocacy skills in meeting health goals, engaging in health activities, utilizing community-health resources, and 	File
	accessing health systems of care; or Individual may need peer modeling to take increased res	d 11/
Continuing Stay Criteria	 Individual continues to meet admission criteria; and Progress notes document progress relative to health goals identified in the Individualized Recovery/Resiliency Plan, but treatment/recovery/wellness goals have not vet been achieved. 	29/23
Discharge Criteria	 An adequate continuing care plan has been established; and one or more of the following: Goals of the Individualized Recovery Plan have been substantially met; or Individual/family requests discharge. 	Page
Service Exclusions	 Individuals receiving Assertive Community Treatment are excluded from this service. (If an ACT team has a Whole Health & Wellness Coach (CPS-WH) can provide this intervention but would bill through that team's existing billing mechanisms). Whole Health & Wellness Coach (CPS-WH) can provide this intervention but would bill through that team's existing billing mechanisms). When whole health and wellness topics are provided within a MH Peer Support program model, this PSWHW code is not utilized as a billable intervention. In this case, the whole health and wellness content is a subcomponent of the MH Peer Support program model. 	284 of 6
Clinical Exclusions	Individuals with the following conditions are excluded from admission unless there is clearly documented evidence of a psychiatric condition co-existing with one of the following diagnoses: Intellectual/Developmental Disabilities, Autism, Neurocognitive Disorder, Substance-Related Disorder, or Traumatic Brain Injury.	27

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Peer Suppo	Peer Support Whole Health & Wellness - Group
	 There is documentation available which evidences a minimum monthly team meeting during which the Whole Health & Wellness Coach/s and the agency- designated RN/s convene to: Promote communication strategies;
200	 b. Confer about specific individual health trends; c. Consult on health-related issues and concerns; and
Components	d. Brainstorm partnered approaches in supporting the person in achieving his/her whole health goals. 2. Services and interventions must be individually tailored to the needs, goals, preferences and assets of the individual with the goals of wellness and recovery as
	defined by the individual. 3 At last 60% of all service units must involve face to face contact with individuals either through an individual or ground Dear Support Whole Health and Welhass
	1. This service is delivered in a group service model.
	Ine roll a.
	b. Practitioner Level 4: Whole Health & Wellness Coach (CPS-WH) with Master's or Bachelor's degree in one of the helping professions such as social work,
	community coursemily, coursemily, by choosy, or chiminology, and the supervision of an incensed independent practitioner. c. Practitioner Level 5: Whole Health & Wellness Coach (CPS-WH) with high school diploma/equivalent under supervision of one of the licensed/credentialed
	 Partnering team members must include: A Whole Health & Wellness Coach (CPS-WH) who promotes individual self-determination, whole health goal setting, decision-making and provides essential
Staffing	health coaching and support to promote activities and outcomes specified above.
Requirements	b. An agency-designated Registered Nurse(s) who provides back-up support to the Whole Health & Wellness Coach (CPS-WH) in the monitoring of each individual's health and providing insight to the Whole Health & Wellness Coach (CPS-WH) as they engage in the health coaching activities described above
	c. There is no more than a 1:12 CPS-to-individual ratio for each facilitated group.
	e. The Whole Health & Wellness Coach (CPS) is the lead practitioner in the service delivery. The RN will be in a health consultation role to the Whole Health &
	weliness Coacn (CPS) and the individuals served. The nurse snould also be prepared to provide clinical consultation to the whole Health & Weliness Coacn (CPS) if there is an emerging health need; however, the individual is in charge of his/her own health process and this self-direction must be acknowledged
	 The agency supports and promotes the participation of Whole Health & Wellness Coaches (CPS-WHs) in statewide technical assistance initiatives which enhance the skills and development of the CPS.
	1. The program shall have an Organizational Plan which will describe the following:
Clinical	b. How the preferences of the individual will be supported in accomplishing health goals;
Operations	
	Whole Health & Wellness Coach (CPS-WH)
	f. The consultative relationship between the Whole Health & Wellness Coach (CPS) and the RN.
Service	There is a minimum contact expectation with an individual weekly, either face-to-face (one-on-one or within a group) or telephonically to track progress on the identified
Accessionity	ilealii goai. Orisuccessidi atterripis to make comact shall be documented.

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Peer Support Whole Health & Weliness - Group

Documentation Requirements

There is documentation available which demonstrates a minimum monthly team meeting during which the Whole Health & Wellness Coach (CPS-WH) and the agency- designated RN/s convene to discuss items identified in Required Components Item 1 in this definition. 1. All applicable Medicaid, ASO, and other DBHDD reporting requirements must be met. 2. There is documentation available which documents.

Peer Suppor	Peer Support Whole Health & Wellness - Individua	s - Indivi	idual										
Transaction Code	Code Detail	Code	Mod 1	Mod 2	Mod Mod 3	Mod Rate 4	Code Detail		Code	Mod 1	Mod 2	Mod M	Mod Rate 4
	Practitioner Level 3, In-Clinic	H0025	U3	90		\$ 30.01		Practitioner Level 3, Out-of- Clinic	H0025	L3	10		\$ 36.68
Health and Wellness	Practitioner Level 4, In-Clinic	H0025	U4	90		\$ 20.30		Practitioner Level 4, Out-of- Clinic	H0025	4	U2		\$ 24.36
Supports (Behavioral Health	Practitioner Level 5, In-Clinic	H0025	U5	90		\$ 15.13		Practitioner Level 5, Out-of- Clinic	H0025	US	U2		\$ 18.15
Prevention Education Service) (Delivery of Services with Target Population to Affect	Practitioner Level 3, Via interactive audio and video telecommunication systems	H0025	GT	U3		\$ 30.01		Practitioner Level 5, Via interactive audio and video telecommunication systems	H0025	GT	US		\$ 15.13
and/or Behavior)	Practitioner Level 4, Via interactive audio and video telecommunication systems	H0025	GT	U4		\$ 20.30							
Unit Value	15 minutes						Utilization Criteria	eria	TBD				
	Definition of Service: This is a one-to-one service in which the Whole Health & Wellness Coach (CPS-WH) assists the individual with setting his/her personal expectations, introducing health objectives as an approach to accomplishing overall life goals, helping identify personal and meaningful motivation, and health/wellness self-management. The individual served should be supported to be the director of his/her health through identifying incremental and measurable steps/objectives that make sense to the person, considering these successes as a benchmark for future success.	to-one ser ectives as a rved shoulc	vice in v in appro I be sup uccesse	hich the ach to ac ported to s as a be	Whole Head complishir be the dire	alth & Welln ig overall life ector of his/h or future suc	which the Whole Health & Wellness Coach (CPS-WH) assists the individual with setting his/her personal roach to accomplishing overall life goals, helping identify personal and meaningful motivation, and health/pported to be the director of his/her health through identifying incremental and measurable steps/objectives as a benchmark for future success.	VH) assists the in entify personal an identifying increm	dividual w d meaning ental and	ith settir yful moti measur	ng his/h ivation, able ste	er person and healt eps/object	al n/wellness ves that
	Health engagement and health management for the individual are key objectives of the service. These should be accomplished by facilitating health dialogues; exploring the multiple choices for health engagement; supporting the individual in overcoming fears and anxiety related to engaging with health care providers and procedures; promoting engagement with health practitioners including, at a minimum, participating in an annual physical; assisting the individual in the work of finding compatible primary physician who is trusted; among other engagement activities.	agement for salth engage with health strusted; ar	r the inc ement; s practitic nong oth	lividual ar upporting oners incl	re key obje g the indivi luding, at a gement act	ctives of the dual in oven minimum, I	service. These shound fears and a	nould be accompli anxiety related to annual physical; a	ished by fa engaging sssisting th	acilitatin with hea with hea indivi	g healtl alth car dual in	dialogue provider the work	s; s and f finding a
Service Definition	Another major objective is promoting access to health supports. This is accomplished by using technology to support the individual's goals; providing materials which assist in structuring the individual's path to prevention, healthcare, and wellness; partnering with the person to navigate the health care system; assisting the person in developing his/her own natural support network which will promote that individual's wellness goals; creating solutions with the person to overcome barriers which prevent healthcare engagement (e.g. transportation, food stamps, shelter, medications, safe environments in which to practice healthy choices, etc.); and linking the individual with other health and wellness resources (physical activity, fitness, healthy/nutritional food).	g access to bath to prevort nort network transports	health sention, leading, which wation, for	upports. healthcar vill promo od stamp ysical act	This is acc e, and wel ore that ind s, shelter, ivity, fitnes	complished I lness; partn ividual's we medications s, healthy/n	n supports. This is accomplished by using technology to support the individual's goals; providing materials which it, healthcare, and wellness; partnering with the person to navigate the health care system; assisting the person in h will promote that individual's wellness goals; creating solutions with the person to overcome barriers which food stamps, shelter, medications, safe environments in which to practice healthy choices, etc.); and linking the physical activity, fitness, healthy/nutritional food).	y to support the in on to navigate the ing solutions with ts in which to practs in which the practical was a second in the practical ways.	ndividual's e health ca the persor	goals; gare system to over	providir em; ass rcome ses, etc	ng materia isting the barriers w barriers w'	s which berson in nich ing the
	The Whole Health & Wellness Coach (CPS-WH) and supporting nurse also provide the following health s 1. Share basic health information which is pertinent to the individual's personal health; 2. Promote awareness regarding health indicators; 3. Assist the individual in understanding the idea of whole health and the role of health screening; 4. Support behavior changes for health improvement;	th (CPS-WF stion which ding health derstanding for health i	4) and suitsis pertinindicatothe ideamprove	upporting ent to the rs; of whole nent;	nurse also individual health an	provide the 's personal d the role of	supporting nurse also provide the following health skill-building and supports: inent to the individual's personal health; tors; tors; as of whole health and the role of health screening; ement;	skill-building and s	supports:				

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m rd}$ Quarter Provider Manual for Community Behavioral Health Providers (January 1, 2023)

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agement, etc.) to wellness; ut not limited to ut not limited to which indicate need for	p g	and other health areas. Procommunity partners fled supporting nurse lth referral and access		, a), one of which is age age bealth symptoms th resources, and	527
 Support Whole Health & Wellness - Individual So Make available wellness tools (e.g. relaxation response, positive imaging, education, wellness toolboxes, daily action plans, stress management, etc.) to support the individual's identified health goals; Frovide concrete examples of basic health changes and work with the individual in his/her selection of incremental health goals; Teach/model/demonstrate skills such as nutrition, physical fitness, healthy lifestyle choices; Promote and offer healthy environments and skills-development to assist the individual in modifying his/her own living environments for wellness; Support the individual as they practice creating healthy habits, personal self-care, self-advocacy and health communication (including but not limited to disclosing history, discussing prescribed medications, asking questions in health settings, etc.); Support the individual to identify and understand how his/her family history, genetics, etc. contribute to their overall health picture; Support the individual in understanding medication and related health concerns; and Support the individual in understanding medication and related health oncerns; and Promote health skills, considering fitness, healthy choices, nutrition, healthy meal preparation, teaching early warning signs/symptoms which indicate need for health intervention, etc. 	Specific interventions may also include supporting the individual in being able to have conversations with various providers to access health support and treatment and assisting individuals in gaining confidence in asserting their personal health concerns and questions, while also assisting the person in building and maintaining self-management skills. Health should be discussed as a process instead of a destination. Assistance will be provided to the individual to facilitate his/her active participation in the development of the Individualized Recovery Plan (IRP) health goals which may include but not be limited to attention to dental health, healthy weight management, cardiac health/hypertension, vision care, substance use disorders (including	smoking cessation), vascular health, diabetes, pulmonary, nutrition, sleep disorders, stress management, reproductive health, human sexuality, and other health areas. These interventions are necessarily collaborative: partnering with health providers and partnering with the individual served in dialogues with other community partners and supporters to reinforce and promote healthy choices. The Whole Health & Wellness Coach (CPS-WH) must also be partnered with the identified supporting nurse and other licensed health practitioners within the organization to access additional health support provided by the organization or to facilitate health referral and access to medical supports external to the organization providing this service.	The interventions are based upon respectful and honest dialogue supported by motivational coaching. The approach is strengths-based: sharing positive perspectives and outcomes about managing one's own health, what health looks like when the person gets there (visioning), assisting a person with re-visioning his/her self-perception (not as "disabled"), assisting the person in recognizing his/her own strengths as a basis for motivation, and identifying capabilities and opportunities upon which to build enhanced health and wellness. The peer-to-peer basis for the service allows the sharing of personal experience, including modeling wellness and mutual respect and support that is also respectful of the individualized process and journey of recovery. This equality partnership between the supported individual and the Whole Health & Wellness Coach (CPS-WH) should serve as a model for the individual as he/she then engages in other health relationships with health services practitioners. As such the identified nurse member of the team is in a supporting role to the Whole Health & Wellness Coach (CPS-WH).	A mind/body/spirit approach is essential to address the person's whole health. Throughout the provision of these services the practitioner addresses and accommodates an individual's unique sense of culture, spirituality, and self-discovery, assisting individuals in understanding shared decision making, and in building relationship of mutual trust with health professionals.	Individual must have two co-existing serious health conditions (hypertension, diabetes, obesity, cardiovascular issues, pulmonary issues, etc.), one of which is either a mental health condition or substance use disorder; and one or more of the following: Individual requires and will benefit from support of Whole Health & Wellness Coaches (CPS-WHs) for the acquisition of skills needed to manage health symptoms and utilize/engage community health resources; or Individual may need assistance to develop self-advocacy skills in meeting health goals, engaging in health activities, utilizing community-health resources, and	accessing health systems of care; or Individual may need peer modeling to take increased responsibilities for his/her own recovery and wellness.
5. Make available wellness support the individual's 6. Provide concrete examy 7. Teach/model/demonstrs 8. Promote and offer healt 9. Support the individual a disclosing history, discut 10. Support the individual transfer of the individual in the individua	Specific interventions assisting individuals in management skills. He Assistance will be proventy include but not be	smoking cessation), va These interventions ar and supporters to reint and other licensed hea to medical supports ex	The interventions are the and outcomes about in perception (not as "dis which to build enhance respect and support the Whole Health & Welling practitioners. As such	A mind/body/spirit app accommodates an indirelationship of mutual	 Individual must ha either a mental he Individual requires and utilize/engage Individual may nee 	accessing health s 4. Individual may ne
Peer Support					Admission Criteria	

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	4	Continuing Stav 1. Individual continues to meet admission criteria; and
quate continuing care plan has been established; and one or more of the following: if the Individualized Recovery Plan have been substantially met; or alifamily requests discharge. Individualized Recovery Plan have been substantially met; or alifamily requests discharge. Individualized Recovery Plan have been substantially met; or and the Valeness Coach (CPS) can provide this intervention but would bill through that team's existing billing mechanisms. Individual read that the billowing conditions are excluded from admirssion unless there is clearly documented evidence of a psychiatric condition co-existing with one of the individual realishe which evidences a minimum monthly team meeting during which the Whole Health & Wellness Coach (CPS-WH), then that is good so when the billowing conditions are excluded from admirssion unless there is clearly documented evidence of a psychiatric condition co-existing with one of the reality and RNR someone is insupporting the person in achieving his/her whole health & Wellness Coach is and the agency- note communication strategies and concerns; and station health-related issues and concerns; and strategies in the person in achieving his/her whole health goals. station health-related suscess and concerns; and station health-related suscess and concerns; and strategies and provide bear supported whole health & Wellness systems/schvities. By the individual. By the individual. By the individual can one-borne service model by a single practitioner to single individual served. By the individual. By the individual whole health & Wellness Coach (CPS-WH) with Master's or Bachelor's degree in one of the helping professions such as social work, mornumly counseling, psychology, or criminology, under the supervision of a licensed independent practitioner. Tractitioner Level 5: Whole Health & Wellness Coach (CPS-WH) with Master's or Bachelor's degree in one of the helping professions such as social work. Whole Health & Wellness Coach (CPS-WH) with brigh school diplomar		Progress notes document progress relative to health goals identified in the Individualized Recovery/Resiliency Plan, but treatment/recovery/wellness goals have not yet been achieved.
Is receiving Assertive Community Treatment are excluded from this service. (If an ACT team has a Whole Health & Wellness Coach (CPS-WH), then that that Assertive Community Treatment are excluded from this service. (If an ACT team has a Whole Health & Wellness Coach (CPS-WH), then that diagnoses: Intellectual/Developmental Disabilities, Autism, Neurocognitive Disorder, Substance-Related Disorder, or Traumatic Brain Injury. In a soft of Commentation available which evidences a minimum monthly team meeting during which the Whole Health & Wellness Coach/s and the agency-paried RNs conven to: In a commentation available which evidences a minimum monthly team meeting during which the Whole Health & Wellness Coach/s and the agency-paried RNs conven to: In a commentation available which evidences a minimum monthly team meeting during which the Whole Health & Wellness Coach/s and the agency-paried RNs conven to: In an anisorm partnered approaches in supporting the person in achieving his/her whole health goals. In an anisorm partnered approaches in supporting the person in achieving his/her whole health and wellness systems/activities. In an anisorm partnered approaches in supporting the person in achieving his/her whole health and wellness systems/activities. In a contact alongside the person to analysia and engage in health and wellness systems/activities. In a contact alongside the person to analysia and engage in health and wellness systems/activities. Practitioner Level S: RN (only when heishe is identified in the agency's organizational chart as being the specific support nurse to the CPS). Practitioner Level S: RN (only when heishe is identified in the agency's organizational chart as being the specific support nurse to the CPS). Practitioner Level S: Whole Health & Wellness Coach (CPS-WH) with high school diplomalequivalent under supervision of one of the licensed fraedence and provide and provides and undornes specified above. An agency-designed Registered Nurse's who provides back-up support to the		dequate continuing care plan has been established; and one or more of the following: s of the Individualized Recovery Plan have been substantially met; or idual/family requests discharge.
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Brainstorm partnered approaches in supporting the person in achieving his/her whole health goals. Vices and interventions must be individually tailored to the needs, goals, preferences and assets of the individual with the goals of wellness and recovery as inded by the individually tailored to the needs, goals, preferences and assets of the individual with the goals of wellness and recovery as inded by the individually tailored to the needs, goals, preferences and assets of wellness experience units must involve face-to-face contact with individuals. The remainder of direct billable service includes telephonic intervention directly at the person or is contact alongside the person to navigate and engage in health and wellness systems/activities. Practitioner Level 3: RN (only when heishe is identified in the agency's organizational chart as being the specific support nurse to the CPS). Practitioner Level 3: RN (only when heishe is identified in the agency's organizational chart as being the specific support nurse to the CPS.) Practitioner Level 3: Whole Health & Wellness Coach (CPS-WH) with high school diploma/equivalent under supervision of one of the licensed/credentialed professionals above. Practitioner Level 5: Whole Health & Wellness Coach (CPS-WH) with high school diploma/equivalent under supervision of one of the licensed/credentialed arthering team members must include: A Whole Health & Wellness Coach (CPS-WH) who promotes individual self-determination, whole health & Wellness Coach (CPS-WH) is the lead practitioner to the Whole Health & Wellness Coach (CPS-WH) is the lead practitioner in the service delivery. The RN will be in a health consultation to the Whole Health & Wellness Coach (CPS-WH) is the lead practitioner in the service delivery. The RN will be in a health consultation to the Whole Health & Wellness Coach (CPS-WH) is right-dividual service delivery. The RN will be the preference of the Whole Health & Wellness Coach (CPS-WH) is right-dividual service and the individual service. The Wh	ن ن	Consult on health-related issues and concerns; and
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Welliess Coach (CPS-VPT) if there is an emerging health need, nowever, the mandal is in charge of mishier own health process and this sen-direction must		Wellness Coach (CPS-WH) if there is an emerging health need; however, the individual is in charge of his/her own health process and this self-direction must
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enhance the skills and development of the CPS.	:	enhance the skills and development of the CPS.

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Peer Suppor	Peer Support Whole Health & Wellness - Individual
Clinical	The program shall have an Organizational Plan which will describe the following: a. How the served individual will access the service; b. How the preferences of the individual will be supported in accomplishing health goals;
Operations	 An organizational chart which delineates the relationship between the Whole Health & Wellness Coach (CPS-WH) and the RN; Whole Health & Wellness Coach (CPS-WH) engagement expectations with the individuals served (e.g. planned frequency of contact, telephonic access, etc.); The consultative relationship between the Whole Health & Wellness Coach (CPS-WH) and the RN.
	1. There is a minimum contact expectation with an individual weekly, either face-to-face or telephonically to track progress on the identified health goal. Unsuccessful attempts to make contact shall be documented. 2. To promote access, providers may use Telemedicine as a tool to provide direct interventions to individuals for whom English is not their first language. Examples
Service Accessibility	 The use of one-to-one service intervention via Telemedicine, connecting the individual to a practitioner who speaks the individual's language versus use of interpreters; and/or the use of an interpreter via Telemedicine to support the practitioner in delivering the identified service.
	Telemedicine may only be utilized when delivering this service to an individual for whom English is not their first language. The individual must consent to the use of this modality. This consent should be documented in the individual's record. The use of telemedicine should not be driven by the practitioner's/agency's convenience or preference.
Documentation Requirements	 All applicable Medicaid, ASO, and other DBHDD reporting requirements must be met. There is documentation available which demonstrates a minimum monthly team meeting during which the Whole Health & Wellness Coach (CPS-WHs) and the agency-designated RN/s convene to discuss items identified in Required Components Item 1 in this definition.
Billing & Reporting Requirements	The only RN/s who are allowed to bill this service are those who are identified in the agency's organizational chart as being the specific support nurse to the CPS-WH for this wellness service. When Telemedicine technology is utilized for the provision of this service in accordance with the allowance in the Service Accessibility section of this definition, the code cited in the Code Detail above with the appropriate GT modifier shall be utilized in documentation and claims submission.

Psychosocia	Psychosocial Rehabilitation - Program	am												
Transaction	Code Detail	Code	Mo	Mo	Mo	Mo	Rate	Code Detail	Code	Mod	Mod Mo Mo	Mo	Mo	Rate
Code			d 1	d2 d3	d 3	d 4				_	d 2	d2 d3	d 4	
Psychosocial	Practitioner Level 4, In-Clinic	H2017	М	U4	90		\$17.72	\$17.72 Practitioner Level 4, Out-of-Clinic H2017	H2017	HQ	U4	LO7		\$21.64
Rehabilitation	Practitioner Level 5, In-Clinic	H2017	Р	U5	90		\$13.20	\$13.20 Practitioner Level 5, Out-of-Clinic H2017	H2017	HQ U5	N2	L 1		\$16.12
Unit Value	Unit=1 hour							Utilization Criteria	TBD					
	A therapeutic, rehabilitative, skill t	ouilding ar	nd reco	very pr	omoting	g servic	e for indiv	A therapeutic, rehabilitative, skill building and recovery promoting service for individuals to gain the skills necessary to allow them to remain in or return to naturally	to allow the	nem to re	main in	or retu	m to na	ıturally
_	occurring community settings and activities. Services include, but are not limited to:	activities	. Servic	ses incl	ude, bu	ıt are π	ot limited t	to:						
Service	1. Individual or group skill buildin	g activitie	s that f	ocns or	n the de	velopn	nent of ski	1. Individual or group skill building activities that focus on the development of skills to be used by individuals in their living, learning, social and working	r living, le	arning, sc	ocial an	d worki	б	
Definition	environments;													
	2. Social, problem solving and coping skill development;	oping skill	develo	pment,										
	3. Illness and medication self-management;	ınagemen	ıţ;											

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Psychosoci	A. Prevocational skills (for example: preparing for the workday; appropriate work aftire and personal presentation including hygiene and use of personal effects such as makeup, jewelly, perfume/cologne etc. as appropriate to the work environment; time management; prioritizing tasks; taking direction from supervisors; appropriate use of break times and sick/personal leave; importance of learning and following the policies/rules and procedures of the workplace safety; problem solving/conflict resolution in the workplace; communication and relationships with coworkers and supervisors; resume and job application development; on-task behavior and task completion skills such as avoiding distraction from work tasks, following a task through to completion, asking for help when needed, making sure deadlines are clarified and adhered to, etc.; learning common work tasks or daily living tasks likely to be utilized in the workplace such as telephone skills, food preparation, organizing/filing, scheduling/participating in/leading meetings, computer skills etc.); and 5. Recreational activities and/or leisure skills which support a goal on the IRP and improve rehabilitation skills necessary for recovery.
	The programmatic goals of the service must be clearly articulated by the provider, utilizing a best/evidence-based model for service delivery and support. These best/evidence-based models may include: The Boston University Psychosocial Rehabilitation approach, the Lieberman Model, the International Center for Clubhouse Development approach, or blended models/approaches in accordance with current psychosocial rehabilitation research. Practitioners providing this service are expected to maintain knowledge and skills regarding current research trends in best/evidence-based models and practices for psychosocial rehabilitation.
	This service is offered in a group setting. Group activities and interventions should be made directly relevant to the needs, desires and IRP goals of the individual participants (i.e. an additional activity/group should be made available as an alternative to a particular group for those individuals who do not need or wish to be in that group, as clinically appropriate).
Admission Criteria	 Individual must have a behavioral health issue (including those with a co-occurring substance use disorder or IID/IDD) and present a low or no risk of danger to themselves or others; and one or more of the following: Individual lacks many functional and essential life skills such as daily living, social skills, vocational/academic skills and/or community/family integration; or Individual needs frequent assistance to obtain and use community resources.
Continuing Stay Criteria	 Behavioral health issues that continue to present a low or no imminent risk of danger to themselves or others (or is at risk of moderate to severe symptoms); and one or more of the following: Individual improvement in skills in some but not all areas; or It services are discontinued there would be an increase in symptoms and decrease in functioning.
Discharge Criteria	 An adequate continuing care plan has been established; and one or more of the following: Individual has acquired a significant number of needed skills; or Individual has sufficient knowledge and use of community supports; or Individual demonstrates ability to act on goals and is self-sufficient or able to use peer supports for attainment of self-sufficiency; or Individual/family need a different level of care; or Individual/family requests discharge.
Service Exclusions	 Cannot be offered in conjunction with SA Intensive Outpatient Program Services. Service can be offered while enrolled in a Crisis Stabilization Unit in a limited manner when documentation supports this combination as a specific need of the individual. Time and intensity of services in PSR must be at appropriate levels when PSR is provided in conjunction with other services. (This will trigger a review by the Administrative Services Organization). This service cannot be offered in conjunction with Medicaid I/DD Waiver services.
Clinical Exclusions	
Required Components	 This service must operate at an established clinic site approved to bill Medicaid for services. However, individual or group activities should take place offsite in natural community settings as is appropriate to the participating individual's Individualized Recovery Plan.

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Psychosocia	Psychosocial Rehabilitation - Program
	 This service may operate in the same building as other day-model services; however, there must be a distinct separation between services in staffing, program described above.
	description, and physical space daming the hours the hoursman specialism except as described above. 3. Adequate space, equipment, furnishings, supplies and other resources must be provided in order to effectively provide services and so that the program
	environment is clean and in good repair. Space, equipment, furnishings, supplies, transportation, and other resources for individual use within the PSR program
	must not be substantially dirrerent from that provided for other uses for similar numbers of individuals. 4. The program must be operated for no less than 25 hours/week, typically during day, evening and weekend hrs. No more than 5 hours/day may be billed per
	A PSR program must operate to assist individuals in attaining, maintaining, and utilizing the skills and resources needed to aid in their own rehabilitation and recovery
	1. The program must be under the direct programmatic supervision of a Certified Psychiatric Rehabilitation Practitioner (CPRP), or staff who can demonstrate
	activity toward attainment of certification (an individual can be working toward attainment of the certification for up to one year under a non-renewable waiver
	which will be granted by the DBHDD). For purposes of this service "programmatic supervision" consists of the day-to-day oversight of the program as it operates
	(including elements such as maintaining the required staffing patterns, staff supervision, daily adherence to the program model, etc.). Additionally the program must be under the clinical exercisht of an independently licensed proditional with the programmation.
Staffing	4. The maximum face-to-face ratio cannot be more than 12 individuals to 1 direct service/program staff (including CPRPS) based on average daily attendance of
nents	individuals in the program.
	5. At least one CPRP (or someone demonstrating activity toward attainment of certification) must be onsite face-to-face at all times (either the supervising CPRP or
	other CPRP staft) while the program operates regardless of the number of individuals participating. All staft are encouraged to seek and obtain the CPRP
	credential. All start must have an understanding of recovery and psychosocial rehabilitation principles as defined by USPRA and must possess the skills/ability to
	6. Programs must have documentation that there is one staff person that is "co-occurring capable." This person's knowledge must go beyond basic understanding
	and must demonstrate actual stail capabilities in using that Knowledge for individuals with co-occurring disorders. Personnel documentation should demonstrate that this chaft parson has posited actually a minimum of 4 hours of training in an acquiring training training the past 2 years.
	Inal mis stait person has received a minimum of 4 hours of training in co-occurring treatment within the past 2 years.
	r. If the program does not employ someone who meets the chiefla for a MAC, CAADC, CCADC-II of -III, of CAC-II, then the program make documentation of access to an addictionologist and/or one of the above for consultation on substance use disorders as co-occurring with the identified mental illness.
	1. Individuals receiving this service must have a qualifying diagnosis present in the medical record prior to the initiation of services. The diagnosis must be given by
	2. Rehabilitation services facilitate the development of an individual's skills in the living, learning, social, and working environments, including the ability to make
	decisions regarding self-care, management of illness, life work, and community participation. The services promote the use of resources to integrate the individual
Clinical	 Kenabilitation services are individual-driven and are founded on the principles and values of individuals in their rehabilitation. Through the provision of both formal and informal artificial individuals are able to influence and chance consist development.
Operations	4. Rehabilitation services must include education on self-management of symptoms, medications and side effects; identification of rehabilitation preferences; setting
	rehabilitation goals; and skills teaching and development.
	are set by exploring strengths and needs in the individual's living, learning, social, and working environments. Implementation of services may take place
	Each Individual must be provided assistance in the development and acquisition of needed skills and resources necessary to achieve stated goals.

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Psychosocial Rehabilitation - Program

- PSR programs must offer a range of skill-building and recovery activities from which individuals choose those that will most effectively support achievement of the individual's rehabilitation and recovery goals. These activities must be developed based on participating individual's input and stated interests. Some of these activities should be taught or led by consumers themselves as part of their recovery process
- makes it difficult to benefit from the PSR program, even with additional or modified methods and approaches, the PSR program must offer co-occurring enhanced approaches that address both disorders at the same time (e.g. groups and occasional individual interventions utilizing approaches to co-occurring disorders such techniques, psychoeducational approaches, relapse prevention planning and techniques etc.). For those individuals whose substance abuse and dependence as motivational interviewing/building motivation to reduce or stop substance use, stage based interventions, refusal skill development, cognitive behavioral A PSR program must be capable of serving individuals with co-occurring disorders of mental illness and substance abuse utilizing integrated methods and services or make appropriate referrals to specialty programs specifically designed for such individuals. ω.
 - 9. The program must have a PSR Organizational Plan addressing the following:
- Philosophical principles of the program must be actively incorporated into all services and activities including (adapted from Hughes/Weinstein):
 - View each individual as the director of his/her rehabilitation process Solicit and incorporate the preferences of the individuals served.
 - Deliana in the nelve total help and facilitate an emperior and the second and the
- Believe in the value of self-help and facilitate an empowerment process.
- iv. Share information about mental illness and teach the skills to manage it.
 v. Facilitate the development of recreational pursuits.
- /alue the ability of each individual with a mental illness to seek and sustain employment and other meaningful activities in a natural community
- vii. Help each individual to choose, get, and keep a job (or other meaningful daily activity).
 - i. Foster healthy interdependence.
- Be able to facilitate the use of naturally occurring resources to replace the resources of the mental health system.
 - b. Services and activities described must include attention to the following:
- Engagement with others and with community.
 - Encouragement.
- Empowerment.
- Consumer Education and Training.
- Family Member Education and Training.
- . Assessment.
- . Financial Counseling.
 - viii. Program Planning.
- ... Relationship Development
 - к. Teaching.
- i. Monitoring.
- xii. Enhancement of vocational readiness.
 - xiii. Coordination of Services.
 - xiv. Accommodations.
- Transportation.
- xvi. Stabilization of Living Situation.

 - xvii. Managing Crises.
 - xviii. Social Life.
- xix. Career Mobility.

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Service Access

Billing and Reporting Requirements

Psychosocial Rehabilitation - Program xx. Job Loss.

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Documentation Requirements

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Psvchosocia	Psychosocial Rehabilitation - Program						
	ts in which the grammatic grou her services du	as actively engaged in servi nd therefore would not be in ge of documented time in/tii	ces. Any t icluded in me out for	ime alloca the reporti PSR-Gro	ted in the proc ng of units of up hours, the	individual was actively engaged in services. Any time allocated in the programmatic description for meals typically up content and therefore would not be included in the reporting of units of service delivered. Should an individual uning the range of documented time in/time out for PSR-Group hours, the absence should be documented on the	
	Now. Rounding is applied to the person's cumulative hours/day at the PSR program (excluding non-programmatic time). The provider shall follow the guidance in the rounding is applied to the person's cumulative hour in order to rounding policy included in this Provider Manual, and, specific to this service, the person served must have participated in at least 50% of the hour in order to bill for one unit of this service. For instance, if an individual participates in the program from 9-1:15 excluding a 30-minute break for lunch, his/her participating hours are 3.75 hours. The rounding policy is applied to the .75 hour and the units billed for that day are 4 units. Practitioner type must still be addressed and so	at the PSR program (exclud cific to this service, the pers participates in the program 7.5 hour and the units bille	ling non-p on served r from 9-1: d for that	rogramma must have 15 excludi day are 4 u	tic time). The participated on a 30-minul inits. Practitio	e hours/day at the PSR program (excluding non-programmatic time). The provider shall follow the guidance in the lal, and, specific to this service, the person served must have participated in at least 50% of the hour in order to an individual participates in the program from 9-1:15 excluding a 30-minute break for lunch, his/her participating applied to the .75 hour and the units billed for that day are 4 units. Practitioner type must still be addressed and so	
	that 4 units must be adequately assigned to either a U4 or U5 practitioner type as reflected in the log for that day's activities. When this service is used in conjunction with Crisis Stabilization Units, Peer Supports, and ACT (on a limited basis), documentation must demonstrate careful planning to maximize the effectiveness of this service as well as appropriate reduction in service amounts of PSR-group based upon current medical necessity. Utilization of psychosocial rehabilitation in conjunction with these services is subject to additional review by the Administrative Services Organization.	U5 practitioner type as refle zation Units, Peer Supports, rell as appropriate reduction these services is subject to	ected in the and ACT in service additional	e log for th (on a limit a amounts	at day's actived basis), doe of PSR-group	ities. cumentation must demonstrate careful based upon current medical necessity. trative Services Organization.	
Residential:	Residential: Community Residential Rehabilitation I (Intensive	sive / Level 1)					
Transaction Code	Code Detail	Code	Mod 1	Mod 2	Mod 3 Mod 4	nd 4 Rate	
Behavioral Health; Long-Term Residential, Without Room and Board, Per Diem	Community Residential Rehabilitation Level I	H0043	83			\$99.23	I I
Unit Value	1 day		Maximun	Maximum Daily Units	ν.	_	
Service Definition	CRR I provides residential rehabilitation services to an individual who require an intensive level of structured support to achieve and enhance their recovery and wellness, increase self-sufficiency and independence, while maintaining community integration. Residential rehabilitation services are individualized goal directed trainings and supports used to restore an individual to the highest level of baseline functioning in the least restrictive and appropriate environment. Services provided include rehabilitative skills building in a variety of areas (such as activities for daily living, health and safety, home and financial management, and personal growth), community integration activities, and rehabilitative supervision. These individualized supports, and who provides them; activities that are fully integrated into the community to achieve community-based supports; and staff support and coordination. This level of residential support requires 24/7 on site awake staff.	lual who require an intensive naintaining community integ hest level of baseline functions (such as activities for da lilitative supervision. These i life choices regarding servic upports; and staff support a	e level of a pration. Reconing in the intological intology, Individually ces and sund coordired and coordired intological into	structured structured sidential re e least res nealth and sed supports, an intion. This	support to act shabilitation so trictive and al safety, home tive residential d who provide i level of resid	nieve and enhance their recovery and ervices are individualized goal directed ppropriate environment. Services and financial management, and al rehabilitative services promote es them; activities that are fully lential support requires 24/7 on site	
	Individuals receiving this level of Community Residential Rehabilitation should experience decreased symptomology (or a decrease in debilitating effects of symptoms), improved social integration and functionality, and increased movement toward self-directed recovery as evidenced by: 1. Reduction in hospitalizations; 2. Reduction in incarcerations; 3. Maintenance of housing stability; 4. Participation in education, vocational training or gainful employment, if this is a goal in the Individualized Recovery Plan; 5. Participation in activities that promote recovery and community integration such as community meetings and other social and recreational activities.	abilitation should experience increased movement towar increased movement towardle increased movement, if this is a community integration such	e decreaserd self-dire	ed sympton cted recov cted recov the sympton cted recovers	nology (or a crery as evider ized Recoverings and other	decrease in debilitating effects of nced by: y Plan; y Social and recreational activities.	
Admission Criteria	Adults aged 18 or older who meet the following criteria:						1

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There is a need for 24/7 awake staff on site to ensure safety and harm reduction to self and others as evidenced by the following: a. Within the past 60 days there is demonstrated evidence of clear and consistent behaviors occurring a minimum of one time per week contributing to risk of harm and safety (i.e. wandering, elopement, poor safety judgment, sleep disturbance resulting in night terror or anxiety, agitation, aggression, poor impulse control, nighttime confusion/disorientation (excluded from 60 day timeframe cited above) that would benefit from 24/7 awake staff support during nighttime hours (SOURCE CITATIONS: Documentation of these behaviors from courts, acute treatment settings (hospitals, CSUs, PRTFs) prison, jails, other residential providers, etc.). AND b. Significant functional impairment and needs assistance in 3 or more of the following areas: inability to maintain hygiene, meet nutritional needs, care for personal business affairs, avoid common dangers or hazards to self and possessions, failure to perform daily tasks with minimal assistance; inability to acarry out homemaker roles. AND c. Lack the ability to live in an independent setting without intensive residential supports and services, demonstrating a need for assistance to care for self in a safe and sanitary manner as evidenced by 3 or more of the following: need assistance with food and clothing, are unable to maintain hygiene, grooming, nutrition, medical or dental care for primary health care conditions, history of hospitalization or at risk of confinement because of dangerous behavior due to inability to manage illness, lack of medication compliance, experience significant issues such as social isolation, poverty, homelessness, behavior due to inability to manage illness, lack of medication compliance, experience significant issues such as social isolation, and cube and such as social isolations.	Individual support, and substance userco-occurring disorders. AND Individuals who utilize this level of service typically have no other viable means of support AND Within the last 180 days attempts at a lower level of residential care have either been considered or tried but have shown little to no effectiveness. AND Individuals with two or more of the following indicators of continuous high service needs; high use of psychiatric hospital, CSU; persistent symptoms that place individual at risk of harm to self or others; co existing substance use of significant duration and chronically homelessness. AND Priority given to those persons recently discharged from a state psychiatric hospital or CSU diagnosed with schizophrenia, other psychotic disorders, or bipolar disorder and clinically assessed as requiring 24/awake staff support. Individual continues to meet admission criteria as described above. Individual continues to benefit from and require intensive residential supports, as evidenced by the Comprehensive Needs Assessment. Housing Goal, and	Residential Functional Assessment. Discharge can take place when: a. An individual or legal representative/guardian withdraws consent or request discharge from this service (refusal to participate in treatment services is not solely a reason for discharge. The Provider must actively engage the individual in the benefit of treatment compliance, thus allowing the individual to make a personal choice to re-engage in services); OR b. An individual has achieved his/her goals in the IRP and has appropriate living arrangements that are less restrictive; OR c. An individual has not achieved his/her goals in the IRP and based on current functioning a higher level of care is recommended.	other residential services are allowable in conjunction with this service. ividuals with the following conditions are excluded from admission unless there is documented evidence of psychiatric condition: Developmental Disability, issm, Neurocognitive Disorder, or Traumatic Brain Injury. Individual can be effectively and safely supported without 24/7 awake staff.

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A primary SPMI diagnosis with functional limitations that severely impair their ability to live in a community-based setting without a high level of residential

support and supervision. AND

Psychosocial Rehabilitation - Program

	disorder and clinically assessed as requiring 24/awake staff support.
Continuing Stay Criteria	 Individual continues to meet admission criteria as described above. Individual continues to benefit from and require intensive residential supports, as evidenced by the Comprehensive Needs Assessment, Housing Goal, and Residential Functional Assessment.
Discharge Criteria	 Discharge can take place when: a. An individual or legal representative/guardian withdraws consent or request discharge from this service (refusal to participate in treatment services is not solely a reason for discharge. The Provider must actively engage the individual in the benefit of treatment compliance, thus allowing the individual to make a personal choice to re-engage in services); OR b. An individual has achieved his/her goals in the IRP and has appropriate living arrangements that are less restrictive; OR c. An individual has not achieved his/her goals in the IRP and based on current functioning a higher level of care is recommended.
Service Exclusions	No other residential services are allowable in conjunction with this service.
Clinical Exclusions	Individuals with the following conditions are excluded from admission unless there is documented evidence of psychiatric condition: Developmental Disability, Autism, Neurocognitive Disorder, or Traumatic Brain Injury. Individual can be effectively and safely supported without 24/7 awake staff.

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	. 2 °.	CRR Hength of stay is between 12-18 months, and should not typically exceed 18 months. The agency providing this service must be either CARF or Joint Commission accredited. Residential setting should not exceed 16 beds for existing providers in operation as of July 1, 2016.	
	4. 70. 0	For residential settings/properties approved for this service after July 1, 2016, no residential treatment setting shall exceed 4 beds. The residential program must provide a structured and supported living environment 24 hours a day, 7 days a week with AWAKE staff on-site at all times.	Cas
	9	Providers will facilitate Quarterly Team Meetings with the Central Office, Regional Field Office, and individual to report findings of quarterly Residential Functional Assessments, review Housing Goal, and discharge transition plan. Where appropriate, specialty services (such as ACT, CST, ICM, and SE)	e 1:1
		should also be included in these quarterly meetings. Documentation of this meeting must be entered into the Electronic Medical Record as a non-billable	16-
		Progress Note.	CV-
	7.	All involuntary discharges must be approved by the Regional Field Office to ensure that the individual is being discharged to a positive housing	03
			08
	ထ် တ်	The service site must be licensed by the Georgia HFR as a PCH or CLA facility which can provide support to those with behavioral health concerns. The Provider and service site must be trained and knowledgeable regarding Protecting the Rights of its individuals as written in the Rules and Regulations set forth by DCH for a DCH or CLA. The home must operate in a manner that respects the personal dignity of the individual.	8-ELF
	10.	Each residential site must be arranged and maintained to provide adequate measures for the health, safety, access and well-being of the residents. Each	2
	7	resident facility must comply with all relevant safety codes.	Do
	- 2	All areas of the residential racinity must be crearl, sale, appropriately equipped, and furnished for the services delivered. The facility must comply with the Americans with Disabilities Act. Specifically, the facility must provide access to ground-level units that meet ADA criteria for	cun
		individuals who have a physical disability.	ner
	. .	The facility must maintain a written evacuation plan to be used in the case of fire or other disaster. An appropriate written certification of compliance must be obtained indicating that all applicable fire and cafety an	nt 4
	14	obtained moraling that all applicable life and safety code requirements have been satisfied. Tenodic life and other safety difficiable be conducted. Evacuation must be clearly marked by exit sings	48
	. 15	Evacuation routes must be used by marked by the register of the state of the program must be responsible for providing physical facilities that are structurally sound and that meet all applicable federal, state, and local regulations for	-73
		adequacy of construction, safety, sanitation, and health.	}
	16.	The site/facility location is integrated within the community and supports access to the greater community.	F
	17	Each individual has privacy in their sleeping or living unit. The common areas should be available to residents.	ile
	<u>∞</u>	Units have lockable entrance doors, with the individual-served and appropriate staff having keys to doors as needed.	d 1
	6. 6	To the best extent possible, individuals sharing units have a choice of roommates.	11/
	5 20	For sites in which an individual might have an extended length of stay, individuals have the freedom to decorate their sleeping or living units.	29
	22.	individuals have needon and support to control their schedules and activities and have access to look any time. To the best extent possible and with respect to other participants, individuals may have visitors at any time, with the exception of during late night hours and	/23
		overnight.	
	23.		Pa
		dividual, as indicated on their IRP. The only exception to this	ige
		expectation is when an individual chooses to opt out due to stable housing, personal choice, etc.	29
	- :	initial manager/supervisor. Residential Managers/Supervisors may be persons with at least 2 years'	96 (
		experience providing imh or AD services and at least a nign school diploma; nowever, this person must be directly supervised by a licensed start member fincturing LMSW TMET APC, or 4-year RN)	of 6
	2	red to be on-site at the CRR I site at least 3x/week to provide oversight and supervision to the staff who provide	527
		direct daily services and supports.	
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Required Components

Psychosocial Rehabilitation - Program

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Staffing Requirements

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Psychosocial	I Re	Psychosocial Rehabilitation - Program
		risk assessments, treatment recommendations, etc.) and modify the individual's IRP as necessary, in accordance with Part II, Section III: Documentation Requirements of this manual, item # 5. Individualized Recovery/Resiliency Planning, sub-item E.
	5.	Because DBHDD is committed to providing choices for housing (based on complete information, including the individual's needs, preferences, and the
		appropriate, available housing options), the residential staff affiliated with this program shall introduce concepts of independent living and promote activities
		towards the goals of successful, individualized, community-integrated housing during the ongoing residential support provided within this service.
	9	CRR I is a transitional residential setting and is NOT intended to provide a long-term residential placement, nor permanent housing. As such, discharge
		planning begins upon admission and should reinforce the therapeutic nature of residential supports to ensure individual stability before discharge.
	7.	When an individual begins to substantially meet IRP goals and objectives, final transition arrangements to the appropriate level of residential care shall begin
		within the next 7 to 14 days (ASO reserves the right to authorize transition days accordingly).
Service	-	Provider shall have a documented process to receive referrals during normal business hours (i.e., fax number where referrals maybe received).
Accessibility	2.	Provider must have a documented process to accept individuals for admission during normal business hours/Monday – Friday, 8 am – 6 pm.
	-	The organization must develop and maintain sufficient written documentation to support the Residential Service for which billing is made. This documentation,
		at a minimum, must confirm that the individual for whom billing is requested was a resident of the Residential Service on the date of service.
	2	The individual's record must also include each week's programming/service schedule in order to document the provision of the required amount of skills
Documentation		training and support activities. Weekly progress notes must be entered in the individual's record to enable the monitoring of the individual's progress toward
Requirements		IRP and recovery goals.
	က	The record should include health issues and how they are being addressed; appointments for psychiatric and medical care that are scheduled for the
		consumer; attendance at other treatments such as substance use disorder counseling that staff may be assisting consumer to attend; assistance provided to
		the consumer to help him or her reach recovery goals; and the consumer's participation in other recovery activities.
Billing & Reporting	-	Each month, the provider must submit a Monthly Residential Programmatic Report developed by DBHDD.
Requirements	2	All applicable ASO, Encounter Data and DBHDD reporting requirements must be adhered to.

	Rate	\$46.43		port to achieve and enhance their bilitation services are individualized goal nd appropriate environment. Services I financial management, and personal e services promote individual initiative.
III (Semi-Independent / Level 3)	<u>~</u>	₽\$	Maximum Daily Units	derate and periodic level of structured sup of community integration. Residential reha asceline functioning in the least restrictive for daily living, health and safety, home an idualized supportive residential rehabilitation
dependen	Mod Mod Mod Mod			require a montaining maintaining hile maintaining hest level of k as activities and y These indiv
emi-Ind	Mod 2			idual who dence, w to the hig sas (such
S) I	Mod 1	R2		an indivindependependependependependependependep
itation	Code	H0043		vices to ance in a vices to a vice and in a varied in a varied in a rehability
Residential: Community Residential Rehabilitation	Code Detail	Community Residential Rehabilitation Level III	day	CRR III provides residential rehabilitation services to an individual who require a moderate and periodic level of structured support to achieve and enhance their recovery and wellness, increase self-sufficiency and independence, while maintaining community integration. Residential rehabilitation services are individualized goal directed trainings and supports used to restore an individual to the highest level of baseline functioning in the least restrictive and appropriate environment. Services provided include rehabilitative skills building in a variety of areas (such as activities for daily living, health and safety, home and financial management, and personal growth), community integration activities, and rehabilitative supervision. These individualized supportive residential rehabilitative services promote individualized
Residential:	Transaction Code	Behavioral Health; Long- Term Residential, Without Room and Board, Per	Unit Value	Service Definition

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	preference, and independence in making life choices regarding services and supports, and who provides them; activities that are fully integrated into the community to achieve community-based supports; and staff support and coordination.
	= 0
	 Maintenance or nousing stability; Participation in education, vocational training or gainful employment, if this is a goal in the Individualized Recovery Plan; Participation in activities that promote recovery and community integration such as community meetings and other social and recreational activities.
	Adults aged 18 or older who meet the following criteria: 1. A primary SPMI diagnosis with functional limitations that severely impair their ability to live in a community-based setting without a high level of residential support and supervision. Individual does not demonstrate complete independence with the basic self-help skills needed to live independently as their desired housing preference;
	AND 2. There is a need for access to 24/7 staff support that is not required to be on site at all times to support and ensure safety and harm reduction to self and others as evidenced by the following:
	a. Significant functional impairment and needs assistance in 2 or more of the following areas: inability to maintain hygiene, meet nutritional needs, care for personal business affairs, avoid common dangers or hazards to self and possessions, failure to perform daily tasks with minimal assistance, inability to carry out homemaker's roles: and
Admission Criteria	 b. Lack the ability to live in an independent setting without residential supports and services, demonstrating a need for assistance to care for self in a safe and sanitary manner as evidenced by 2 or more of the following: need assistance selecting proper clothing, engaging in medical and dental care, following recommendations or primary health condition in a home setting, inability to self-administer medications a prescribed, experiences with significant issues such as social isolation, poverty, homelessness, no family support, substance use/co-occurring disorders; AND
	 Individuals with two or more of the following indicators of continuous high service needs: high use of hospital, CSU; persistent symptoms that place individual at risk of harm to self or others; co existing substance use of significant duration and chronically homelessness; AND
	 Priority will be given to individuals who: a. Have recently discharged from a state psychiatric hospital or CSU; b. Have been diagnosed with schizophrenia, other psychotic disorders, or a bipolar disorder; c. Are transitioning from CRR Level I; or d. Have been clinically determined to require access to 24/7 staff support, although staff are not necessarily on-site at all times.
Continuing Stay Criteria	 Individual continues to meet admission criteria as described above; AND Individual continues to benefit from and require moderate residential supports, as evidenced by the Comprehensive Needs Assessment, Housing Goal, and Residential Functional Assessment.
Discharge Criteria	Discharge can take place when: 1. An individual or legal representative/guardian withdraws consent or requests discharge from this service (Refusal to participate in treatment services is not solely a reason for discharge. The Provider must actively engage the individual in the benefit of treatment compliance, thus allowing the individual to make a personal choice to re-engage in services); OR 2. An individual has achieved his/her goals in the IRP and has appropriate living arrangements that are less restrictive; OR 3. An individual has not achieved his/her goals in the IRP, and based on current functioning a higher level of care is recommended.

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Service Exclusions	 No other residential services are allowable in conjunction with this service. Congregate Apartment Settings (unless the location has the proper licensure through HFR). Pairing this residential setting with any housing/rental payment subsidy that is considered long term and permanent is not allowed. 	
Clinical Exclusions	Individuals with the following conditions are excluded from admission unless there is documented evidence of psychiatric condition: Developmental Disability, Autism, Autism, Neurocognitive Disorder, or Traumatic Brain Injury. Individual can be effectively and safely supported without 24/7 staff support.	(
	1. CRR III length of stay is between 12-18 months, and should not typically exceed 18 months. 2. The agency providing this service must be either CARF or Joint Commission accredited.	Case
		1:1
	4. For residential settings/properties approved for this set vice after July 1, 2010, no residential treatment setting shall exceed 4 beds. 5. The residential program must provide a structured and supported living environment 24 hours a day, 7 days a week, with a minimum of 36 hours of on-site staff.	. <mark>6-</mark> с
	ш с	v-03
	noted as a notice of this meeting must be entered into the Electronic Medical Record as a non-billable Progress Note.	308
	7. The service site must be licensed by the Georgia HFR as a PCH or CLA facility which can provide support to those with behavioral health concerns, in	8-E
	accordance with those rules and regulations. However, the computation some sites may be such that they do not require incensure. R. The Provider and service site must be trained and knowledgeable regarding Protecting the Rights of its individuals as written in the Rules and Regulations set	LR
	9. Each residential site must be arranged and maintained to provide adequate measures for the health, safety, access and well-being of the residents. Each resident facility must comply with all relevant safety codes	Do
	10. All areas of the residential facility must be clean, safe, appropriately equipped, and furnished for the services delivered.	cur
	The facility must comply with the Americans with Disal	nei
	-	nt 4
Required	12. The facility must maintain a written evacuation plan to be used in the case of fire or other disaster. An appropriate written certification of compliance must be	448
Components	obtained indicating that all applicable fire and safety code requirements have been satisfied. Periodic fire and other safety drills must be conducted.	8-7
	13. Evacuation Foutes must be dearly marked by exit signs. 14. The program must be responsible for providing physical facilities that are structurally sound and that meet all applicable federal, state, and local regulations for	3
	w	F
	•	ile
		d 1
	17. Units nave lockable entrance doors, with the Individual-served and appropriate start naving keys to doors as needed. 18. To the hest extent possible individuals sharing units have a choice of nonmates.	1/2
		29/2
	_	23
	st extent possible and with respect to other participants, individuals may have visitors at any time, with the exception of during late night hours and	
	Overnight. As a need of the relevation for whom an individual will make to heavise of his desire the Hermins Obeside and Neede Evelvation	Pa
	22. As a part of the planning for when an individual will move to nousing of mis/net own choice, the Housing Choice and Needs Evaluation https://dbhddapps.dbhdd.ga.gov/NSH/ must be completed at admission and annually for every individual as indicated on their IRP. The only exception to this	ge :
	expectation is when an individual chooses to opt out due to stable housing, personal choice, etc.	300
	ity lease must be in the name of the provider, and not in the individual participant's name, to allow for fluidity of individuals that may be served. The few outliers to this item, DBHDD will work on transitional expectations for other service delivery modalities which can be enacted on or around) of 6
	July 1, 2022).	527

kperijuk kperijuk nclud ne R	Residential sites are required to have an on-site residential manager/supervisor. Residential Managers/Supervisors may be persons with at least 2 years' experience providing MH or AD services and at least a high school diploma; however, this person must be directly supervised by a licensed staff member (including LMSW, LMFT, APC, or 4-year RN). The Residential Manager/Supervisor is required to be on-site at the CRR I site at least 3x/week to provide oversight and supervision to the staff who provide direct daily services and supports.
ersons with high schriebs as ensons with high schriebs and a Supervision of a Recovider should make	Persons with high school diplomas, GEDs or higher, who have completed the paraprofessional training required for DBHDD contracted organizations and under the supervision of a Residential Manager may perform residential services. Provider should make adjustments for increased staffing as appropriate based on the clinical needs of the individuals living with the residential program.
Individuals must be ass support:	Individuals must be assisted with the below items within the first 7 days of admission and every 90 days to determine appropriateness for this level of residential support:
i. Applying for ii. Submitting a iii. Identification	Applying for and obtaining vital records. Submitting appropriate benefit/entitlement applications to assist with the financial demands of independent living. Identification of natural supports (i.e. family, friends, and support groups) and ways to strengthen/utilize them while living in the community.
iv. Linkage to ac Services can lose this resid	Linkage to adult mental health and/or substance use disorder services, as well as primary care providers and/or specialty services as applicable. Services can be provided by a Core or Private Psychiatrist and individual choice/preference should always be considered. Individuals served shall not lose this residential support as a result of his/her choice to opt out of other behavioral health support/medical treatment services (unless these services
are otherwise b. A Housing Goal the and locations), and c. A Primary and Sector	are otherwise required by a federal program/fund source supporting a specific individual). A Housing Goal that clearly states the desire of the individual, identifies available housing opportunities, resources, and supports (i.e. housing types, costs, and locations), and promotes opportunities for continued growth, independence, and community integration. A Primary and Secondary/Contingency Transition Plan that clearly identifies the steps needed to achieve the desired Housing Goal and address any barriers to transition.
 d. A Residential Crisis Response Plan the diverts the loss of housing and promote residential services specialist in the even A Residential Functional Assessment. 	A Residential Crisis Response Plan that guides the residential provider's response to an individual's crisis episode while receiving residential services that diverts the loss of housing and promotes housing stability. This plan shall be developed in partnership with the individual and offer 24/7 access to a residential services specialist in the event of a crisis. A Residential Functional Assessment.
CRR III provides a minimum of (3) hours of week achieve/enhance their recovery and increase self skills necessary for the individual to live in a lesse a. Rehabilitative Skill Building which include	CRR III provides a minimum of (3) hours of weekly residential rehabilitation services to an individual who requires an intensive level of structured support to achieve/enhance their recovery and increase self-sufficiency. These services can only be provided by residential staff and must be focused on independent living skills necessary for the individual to live in a lesser structured setting. Examples of Residential Rehabilitative Skill Building which includes:
: :≓	Activities for daily living, especially those involving maintaining personal hygiene and proper grooming/dress Health and Safety interventions aimed at assisting individuals with access to behavioral health, substance use, and medical treatment services, as well as continuous engagement and adherence to these services; symptom identification and wellness management that promotes appropriate behaviors
and safety in the safety in th	and safety in the community, and self-administration of medication. Home Management, to include meal planning, preparation, and cooking; laundry and housekeeping Financial Management that promotes the ability to manage personal finances and entitlements Personal Growth that allows an individual to express housing choice and preference, develop better communication and social skills through the use of
boping salis an Community Integrate b. Community Integrate higher learning; enga c. Rehabilitative Superservices must be delivered	Community Integration Activities which allow for opportunities to seek employment and work in competitive integrated settings; attend institutions for higher learning; engage in community life; learn the skills necessary to utilize natural supports in the community. C. Rehabilitative Supervision that requires staff to monitor the individual's response to treatment interventions and make adjustments to the IRP as indicated. Services must be delivered to individuals according to their IRP.

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Service

Accessibility

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Documentation Requirements ←. ~.

Billing & Reporting

Requirements

Residential: (Residential: Community Residential Rehabilitation	Rehabi	litation	>										
Transaction Code	Code Detail	Code	Mod 1	Mod 2	Mod Mod Mod 2 4		Rate	Code Detail	Code	Mod I	Mod 2	Mod N	ModModModModRate1234	ate
Community- based Wrap Around Services	Community Living Supports IV	H2021	NA				\$13.96							
Unit Value	15 minutes							Utilization Criteria	TBD					
Service Definition	CRR IV provides rehabilitative skills building, acquisi rehabilitative supervision in scattered site residential term assistance for individuals with a serious mental housing, continue with their recovery, and increase s is, for instance, unable to get out of bed without encc	cills buildir ered site ith a serio very, and	ng, acqui residentis us menta increase ithout en	sition and al location al illness self-suff courager	d training ns occup in an ext iciency (i	g activitie vied by the treme sit such as nnable to	es for daily li ne individua uational cris major depre muster ene	CRR IV provides rehabilitative skills building, acquisition and training activities for daily living, home and personal management, community integration and rehabilitative supervision in scattered site residential locations occupied by the individual in their own residence, even if temporary. The service provides limited short-term assistance for individuals with a serious mental illness in an extreme situational crisis that requires a temporary residential support to maintain and retain stable housing, continue with their recovery, and increase self-sufficiency (such as major depressive episode when an individual is not so critical to warrant hospitalization, but is, for instance, unable to get out of bed without encouragement or unable to muster energy/focus to manage a meal for self).	nent, comr nporary. Tl intial suppo s not so cr If).	munity i he servi ort to m itical to	ntegratice provaintain	ion and vides lim and reta nt hospit	iited sho ain stable alization	e , but
	This is an intervention that is del jeopardize their housing due to s	ivered in c	order to p	revent a lization.	n extrem CRR IV	e crisis t is only u	that may restilized until	This is an intervention that is delivered in order to prevent an extreme crisis that may result in a significant loss of an individual's daily functioning, which could jeopardize their housing due to subsequent destabilization. CRR IV is only utilized until an individual can regain basic management of critical daily self-care. When an	tual's daily	/ functio	ning, w I daily s	hich col	uld . When a	an

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Residential: (Residential: Community Residential Rehabilitation IV
	illness has created a personal circumstance where there is a time-limited demand for personal care. Following a time of decompensation or during a physical health/behavioral health change, this service can be used to: 1. Provide services to an individual who requires personal care in their own home (e.g. assistance with house cleaning, trash removal. medication organization); and 2. Programming should consist of services to restore and develop skills in functional activities; regain or maintain housing and tenancy, supported employment; develop or maintain social relationships. This service allows for the provision of housing supports, which are interventions that support an individual's ability to prepare for and transition to housing, such as: 1. Developing housing support crisis plan and/or coordinating with the individual to review, update and modify their housing support plan and crisis plans as part of their IRP. 2. Early interventions for behaviors that might jeopardize housing, e.g., late rent payment, lease violations. The following personal services interventions are applicable: 1. Supporting the individual in reclaiming stable living situation; 2. Monitoring or providing individual assistance with basic daily healthy maintenance activities, meal preparation, and light housekeeping; 3. Limited assistance with bathing, self-grooming and hygiene;
	 Assistance with self-medication; self-administration of medications, medical and health care adherence, symptom identification and management; Assistance for the individual with Meal Planning, Budgeting and Money Management, Laundry, Housekeeping.
Admission Criteria	 Individuals ages 18 and older with a primary SPMI diagnosis with functional limitations that require the temporary need <u>for personal care services not to exceed 30 days, unless the individual meets continuing stay criteria.</u> Individuals who utilize this level of service typically have no other viable means of support, have the inability to live in an independent setting due to an immediate crisis and personal care services has been identified for continued recovery/wellness and housing stability. Individual needs assistance in 3 or more of the following areas: maintain hygiene, meet nutritional needs, care for personal business affairs, avoid common dangers or hazards to self and possessions, failure to perform daily tasks with minimal assistance; inability to carry out homemaker roles. Individuals who are authorized for community-based services such as ACT, ICM, OR, or CST are eligible if the individual meets admission criteria, and if there is documented need for non-duplicative, complementary support to provide community and housing stabilization.
Continuing Stay Criteria	 Individual continues to be in a crisis that require the need for personal care services and continues to demonstrate need for assistance in 3 or more of the following areas: maintain hygiene, meet nutritional needs, care for personal business affairs, avoid common dangers or hazards to self and possessions, failure to perform daily tasks with minimal assistance; inability to carry out homemaker roles. Individual must have a residential functional assessment at minimum of every 30 days to determine appropriateness for this level of support.
Discharge Criteria	 Individual can effectively and safely be supported with a more appropriate level of service due to change in individual's level of functioning; and no longer meets admission criteria. Individual or appropriate legal representative, requests discharge. Provider will make significant efforts to reinforce therapeutic and residential supports to ensure client stability before an involuntary discharge occurs. Refusal of to participate in treatment services is not solely a reason for discharge. Provider must actively engage individual in the benefit of treatment compliance thus allowing the individual to make a personal choice to re-engage in services. The CRR programs are transitional in nature, intended to support stabilization, promote wellness and recovery and begin to work towards achievement of the individual's longer-term housing goal. As such, discharge planning begins upon admission.
Clinical Exclusions	Individuals with the following conditions are excluded from admission unless there is documented evidence of a psychiatric condition: Developmental Disability Autism, Neurocognitive Disorder, or Traumatic Brain Injury.
Service Exclusions	 CRR I, III Agency staff meeting the staffing requirements may deliver CRR IV as a separate and distinct service from any other community-based or authorized Adult Mental Health service.

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ential: Co	Residential: Community Residential Rehabilitation IV	
<u>+. α. κ. 4.</u>	The agency providing this service is CARF or Joint Commission accredited. In addition to receiving this service, individuals should be linked to adult mental health and/or substance use disorder services, as applicable, including Core or Private psychiatrist and specialty services; however, individuals served shall not lose this support as a result of his/her choice to opt out of other behavioral health support/treatment services (unless these services are otherwise required by a federal program/fund source supporting a specific individual). The organization must have an executive director or program director charged with the responsibility for day-to-day management of the organization. There must be a written Residential Crisis Response Plan that quides the residential provider's response to an individual's crisis episode while receiving CRR IV.	Case
Required Components 5.		1:16-cv-03088-E
Staffing 2.	Persons with high school diplomas, GEDs, or higher degrees may provide direct support services under the supervision of a licensed staff member (including LMSW/LCSW, LAPC/LPC, LAMFT/LMFT, or licensed psychologist), or a 4-year RN. A staff person must be available 24/7 to respond to emergency calls within one hour. A minimum of one (1) staff member per twenty (20) individuals served may not be exceeded.	LR Docu
. 2	 CRR IV provides residential personal care services to an individual with a minimum of one (1) in-person face-to-face contact with the individual in their home each week to maintain stable housing, continue with their recovery, and increase self-sufficiency. The outcomes will focus on: a. Recovery, housing, employment, and meaningful life in the community; b. Maintenance of housing stability; and c. Participation in education, vocational training or gainful employment, if this is a goal in the Individualized Recovery Plan; Participation in activities that promote recovery and community integration. 	ment 448-73
Billing and 1. Reporting 2. Requirements	All a Each	iled 11
Documentation 2. Requirements 3.	 The organization must develop and maintain sufficient written documentation to support the services for which billing is submitted. This documentation, at a minimum, must confirm that the individual for whom billing is requested was enrolled in CRR IV on the billing date and that support services are being provided as required. Each note must be signed and dated and must include the professional designation of the individual making the entry. Documentation must be legible and concise and include the printed name and the signature of the treating practitioner. The name, title, and credentials of the individual providing the service must reflect the staffing requirements established for Independent AD Residential Services being delivered. Providers are required to have a qualifying verified diagnosis present in the individual's case record prior to the initiation of services. 	L/29/23 Page
al: Ind	Residential: Independent AD Residential Services Transaction Code Detail Code Mod	304 of 627

Residential: Independent AD Residential Services Transaction Code Detail Mod		Mod Rate Code Detail Code Mod Mod Mod Mod Rate	1 2 3 4
Residential: Independent AD Residentia Transaction Code Detail Code	l Services	70	1
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			s with a Substance Usuals who have establi ation with focus on ea		ary efforts.		iity while receiving the	dentified that are app		/ support/care.		of others and/or fails to comply with the program rules and therapeutic interventions that have not been	nterventions that have e condition: Developn	nterventions that have condition: Developn	nterventions that have e condition: Developnion.	nterventions that have e condition: Developnion.	nterventions that have e condition: Developnion.	e condition: Developnion.	e condition: Developnion.	e condition: Developnion. e condition: Developnion. procedures to follow in the individual and allorance use disease.	e condition: Developnion. ion. procedures to follow the individual and allowhave substance use designed.
		TBD	nment for individuals ironment for individu ntain basic rehabilits vention skills.	ال. »sidential program.	ed by current recove free environment.		living in the commun	roblems have been i		ses further recover)		es and therapeutic ir	e of a substance us	e of a substance us	e of a substance use of a substance use	e of a substance use of a Substance use les Regulation Divisions.	e of a substance use of a Substance use les Regulation Divisinds.	e of a substance use of a substance use les Regulation Divisions:	e of a substance use of a substance use les Regulation Divisinds.	e of a substance use of a substance use les Regulation Divisions. The providers with in partnership with the individuals who I	e of a substance use of a substance use les Regulation Divisions. Ids. Is the providers with in partnership with the in partnership with the substance use the providers with the individuals who I with ind
		Utilization Criteria	uctured living enviror ing in a recovery envents continue to mail port, and relapse pre	of the most recent DSN a AD Independent Re	vel of care as indicate an alcohol and drug	covery;	dapt to independent I	ervice plan or new pr	a has not been met.	n. The individual refu provided by this leve		with the program rule	with the program rule	with the program rule documented evidence nent services;	with the program rule Jocumented evidenα nent services; th. Healthcare Faciliti	with the program rule Jocumented evidence Jocumented evidence Jocumented Evidence The Healthcare Facilities Programme and unadear	with the program rule	with the program rule documented evidence tent services; th, Healthcare Facilitiential responsibilities. Evenings and weeker its.	with the program rule documented evidenα documented evidenα th, Healthcare Facilities ential responsibilities. Evenings and weeker it. Sonse Plan that guide s shall be developed	with the program rule documented evidence tent services; th, Healthcare Facilitiential responsibilities. Evenings and weeker its. Sonse Plan that guide a shall be developed a shall be developed	with the program rule documented evidence that services; th, Healthcare Facilities. Evenings and weeker k. Sonse Plan that guide s shall be developed experience working weeker standards.
		Utiliza	ousing with a supportive and structured living environment for individuals with a Substance Use Disord ned to promote independent living in a recovery environment for individuals who have established and require 24/7 supervision. Residents continue to maintain basic rehabilitation with focus on early recove ools for developing positive support, and relapse prevention skills.	Use Disorder as defined ir	te in or be successful with this level of care as indicated by current recc Residence service that provides an alcohol and drug free environment.	residents to maintain ongoing recovery;	maintain recovery and rea	n. he goals in the treatment/k	place but discharge criteri	the treatment/service pla /services which cannot be of care.	The state of the s	ers and/or fails to comply	of others and/or falls to comply with the program rules and therapeutic interventions that have not been from admission unless there is documented evidence of a substance use condition: Developmental Disability, injury;	ers and/or fails to comply admission unless there is others; quire withdrawal manager	ers and/or fails to comply admission unless there is a thers; quire withdrawal manager care.	ers and/or fails to comply admission unless there is quire withdrawal managencare. rtment of Community Head of visits to assist with residentials and contained including the complexity of the contained of the	ers and/or fails to comply admission unless there is others; quire withdrawal managencare. Triment of Community Heart of Sare, and visits to assist with resid ividuals' needs, including ith the individual each wee	ers and/or fails to comply admission unless there is quire withdrawal managen are. rtment of Community Heal of visits to assist with resid lividuals' needs, including lith the individual each weekind Residential Crisis Re	of others and/or fails to comply with the program rules and therapeutic interventions that have not b from admission unless there is documented evidence of a substance use condition: Developmental njury; f, or others; to require withdrawal management services; el of care. Department of Community Health, Healthcare Facilities Regulation Division. eduled visits to assist with residential responsibilities. as individuals' needs, including evenings and weekends. act with the individual each week. alth and Residential Crisis Response Plan that guides the providers with procedures to follow during and housing stability. Both plans shall be developed in partnership with the individual and allow 24/7	ers and/or fails to comply admission unless there is a quire withdrawal managen trans. The sare. I wist to assist with resid of visits to assist with resid inviduals' needs, including inth the individual each wee and Residential Crisis Responsing stability. Both plar er with at least 3 years of	ers and/or fails to comply admission unless there is quire withdrawal managen are. It ment of Community Heal of visits to assist with resid ividuals' needs, including ith the individual each were and Residential Crisis Responsing stability. Both plarer with at least 3 years of
Se	R.		ecovery housing sion designed to does not require ces use, tools for	riteria: or a Substance U at this time to ber	participate in or	of fellow resider	is necessary to norovider.	of the admission.	completion is in p	nd objectives of prints treatments to the treatment to the treatments to the treatments to the treatments to the treatment to the treatme	treatment of othe		excluded from a	excluded from actic Brain Injury; o staff, self, or ot ich appear to req	excluded from actic Brain Injury; o staff, self, or ot ich appear to requippe higher level of content of the Depared by the Deparement of the perfection of the Deparement of	excluded from actic Brain Injury; o staff, self, or ot ch appear to requipment level of contract level	excluded from actic Brain Injury; o staff, self, or oth appear to requippe Injury injury in the Inju	excluded from actic Brain Injury; 5 staff, self, or other appear to requippe level of continuous scheduled commodates individual Health ar avioral Health ar	excluded from actic Brain Injury; a staff, self, or of ch appear to required by the Depart wides scheduled commodates individual end had a crisis	excluded from actic Brain Injury; staff, self, or other appear to requipper level of control of the Depart wides scheduled commodates individual Health ar avioral Health ar tof a crisis.	excluded from actic Brain Injury; staff, self, or other appear to requipment level of certain by the Depart wides scheduled commodates indivariant Health ar schoral Health ar ochavioral and health ar tof a crisis.
al oervice	H0043 HF		es provides re nimal supervis sobriety and ct of substanc	he following crastic criteria for pritive ability a	d an ability to of an AD Inde	peer support	and strengths	et the criteria o ss but has not	entation and co	d the goals an other appropriment	uptive to the tr	es.	es. Inditions are e	es. Inditions are est, or Traumat to dangerous to ymptoms whic	by the property of the propert	by anditions are enditions are enditions are enditions are considered and ymptoms which incriteria for a fourth be licensed al Service province and the fourth and the four	anditions are e sr, or Traumati dangerous to ymptoms whic criteria for a f rust be license al Service pro time that acc n of 1 face-to-	anditions are ending and inditions are ending and another individual and individu	anditions are enditions are enditions are enditions are enditional contents and service provision of 1 face-to-chensive Behabit in the event	anditions are enditions are enditions are enditions are enditional cardenations. It is a second to the content of the content	anditions are enditions are enditions are endangerous to ymptoms which criteria for a funt be licensed al Service proviume that accountime that accountime that accountime the event from me minimal Lending in but the event are minimal Lending in control of the event are minimal Lending in the even
Kesidential: Independent AD Kesidential Services	Addictive Diseases H0	Unit= 1 day	AD Independent Residential Services provides recovery housing with a supportive and structured living environment for individuals with a Substance Use Disorder. This is a lower level of care with minimal supervision designed to promote independent living in a recovery environment for individuals who have established and maintained some consistent level of sobriety and does not require 24/7 supervision. Residents continue to maintain basic rehabilitation with focus on early recovery skills that include the negative impact of substances use, tools for developing positive support, and relapse prevention skills.	Adults aged 18 or older who meet the following criteria: 1. The individual meets the diagnostic criteria for a Substance Use Disorder as defined in the most recent DSM. 2. The individual has sufficient cognitive ability at this time to benefit from admission to the AD Independent Residential program.	The individual has demonstrated an ability to participate in or be successful with this level of care as indicated by current recovery efforts. The individual requires support of an AD Independent Residence service that provides an alcohol and drug free environment.	The individual benefits from the peer support of fellow residents to maintain ongoing recovery; The individual does not require twenty-four hours a day on-site supervision by clinical staff and	The individual exhibits the skills and strengths necessary to maintain recovery and readapt to independent living in the community while receiving the minimal clinical and peer support provided by the treatment provider.	The individual continues to meet the criteria of the admission. The individual is making progress but has not yet achieved the goals in the treatment/service plan or new problems have been identified that are appropriately treated in this level of care.	A timeline for expected implementation and completion is in place but discharge criteria has not been met.	The individual has accomplished the goals and objectives of the treatment/service plan. The individual refuses further recovery support/care. The individual will be referred to other appropriate treatment/services which cannot be provided by this level of care. The individual has received maximum benefit from this level of care.	The individual's behavior is disruptive to the treatment	יסיטי טיווי שווייוסטטיווו ווויסטטטטטטט	Individuals with the following conditions are excluded from Autism, Neurocognitive Disorder, or Traumatic Brain Injury;	Autism, Neurocognitive Disorder, or Traumatic Brain Injury; The individual is experiencing symptoms which appear to require withdrawal management services;	Individuals with the following conditions are excluded from admindividuals with the following conditions are excluded from admindiam. Neurocognitive Disorder, or Traumatic Brain Injury; The individual exhibits behavior dangerous to staff, self, or other The individual is experiencing symptoms which appear to require The individual meets admission criteria for a higher level of care. If applicable, the organization must be licensed by the Department.	Individuals with the following conditions are excluded from admission unless there is documented evidence of a substance use conditions are excluded from admission unless there is documented evidence of a substance use conditions. Autism, Neurocognitive Disorder, or Traumatic Brain Injury; The individual exhibits behavior dangerous to staff, self, or others; The individual is experiencing symptoms which appear to require withdrawal management services; The individual meets admission criteria for a higher level of care. If applicable, the organization must be licensed by the Department of Community Health, Healthcare Facilities Regulation Division. The AD Independent Residential Service provides scheduled visits to assist with residential responsibilities.	Individuals with the following or are excluded from admission unless there is documented evidence of Autism, Neurocognitive Disorder, or Traumatic Brain Injury; The individual exhibits behavior dangerous to staff, self, or others; The individual is experiencing symptoms which appear to require withdrawal management services; The individual meets admission criteria for a higher level of care. If applicable, the organization must be licensed by the Department of Community Health, Healthcare Facilities The AD Independent Residential Service provides scheduled visits to assist with residential responsibilities. Services must be provided at a time that accommodates individuals' needs, including evenings and weekends. This service requires a minimum of 1 face-to-face contact with the individual each week.	Individuals with the following on Traumatic Brain Injury; Individuals with the following conditions are excluded from admission unless there is documented evidence of a substance use condition: Developmental Autism, Neurocognitive Disorder, or Traumatic Brain Injury; The individual exhibits behavior dangerous to staff, self, or others; The individual exhibits behavior dangerous to staff, self, or others; The individual meets admission criteria for a higher level of care. If applicable, the organization must be licensed by the Department of Community Health, Healthcare Facilities Regulation Division. The AD Independent Residential Service provides scheduled visits to assist with residential responsibilities. Services must be provided at a time that accommodates individuals' needs, including evenings and weekends. This service requires a minimum of 1 face-to-face contact with the individual each week. There must be a written comprehensive Behavioral Health and Residential Crisis Response Plan that guides the providers with procedures to follow during there must be a written comprehensive Behavioral Health and Residential Crisis Response Plan that guides the providers with procedures to follow during	Individuals with the following conditions are excluded a Autism, Neurocognitive Disorder, or Traumatic Brain II. The individual exhibits behavior dangerous to staff, sel The individual is experiencing symptoms which appear The individual meets admission criteria for a higher level applicable, the organization must be licensed by the The AD Independent Residential Service provides schoservices must be provided at a time that accommodate This service requires a minimum of 1 face-to-face cont There must be a written comprehensive Behavioral He and immediately after the crisis, resulting in behavioral access with the appropriate staff in the event of a crisis.	Individuals with the following conditions are excluded for Autism. Neurocognitive Disorder, or Traumatic Brain In The individual exhibits behavior dangerous to staff, sel The individual is experiencing symptoms which appear The individual meets admission criteria for a higher levil applicable, the organization must be licensed by the The AD Independent Residential Service provides schosenices must be provided at a time that accommodate This service requires a minimum of 1 face-to-face cont There must be a written comprehensive Behavioral Heand immediately after the crisis, resulting in behavioral access with the appropriate staff in the event of a crisis Providers shall have a part/full time minimal Level 4 prac	Autism. Neurocognitive Disorder, or Traumatic Brain Injury; Autism. Neurocognitive Disorder, or Traumatic Brain Injury; The individual exhibits behavior dangerous to staff, self, or others; The individual exhibits behavior dangerous to staff, self, or others; The individual exhibits behavior dangerous to staff, self, or others; The individual is experiencing symptoms which appear to require withdrawal management services; The individual is experiencing symptoms which appear to require withdrawal management services; The individual is experiencing symptoms which appear to require withdrawal management services; The individual is experiencing symptoms which appear to require withdrawal management services. If applicable, the organization must be licensed by the Department of Community Health, Healthcare Facilities Regulation Division. The AD Independent Residential Service provides scheduled visits to assist with residential responsibilities. Services must be provided at a time that accommodates individuals needs, including evenings and weekends. This service requires a minimum of 1 face-to-face contact with the individual each week. There must be a written comprehensive Behavioral Health and Residential Crisis Response Plan that guides the providers with procedures to follow during and immediately after the crisis, resulting in behavioral and housing stability. Both plans shall be developed in partnership with the individual and allow 24/7 access with the appropriate staff in the event of a crisis. Providers shall have a partifull time minimal Level 4 practitioner with at least 3 years of experience working with individuals who have substance use disorders, who is responsible for the day to day operations.
. Inde	Addic	Unit=	AD I This main skills	Adulf 1	დ. 4. 			2	3.	2. 2. 3. 1. 1	4		" " " "			.	.				- 5 6 4 - 5 6 4 6 F 6
Kesidenila	Supported Housing	Unit Value	Service Definition		Admission	Cilleria		Continuing Stay		Discharge	Сптепа		Clinical	Clinical Exclusions	Clinical Exclusions	Clinical Exclusions	Clinical Exclusions Required	Clinical Exclusions Required Components	Clinical Exclusions Required Components	Clinical Exclusions Required Components	Clinical Exclusions Required Components

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Residential:	Indep	Residential: Independent AD Residential Services
	4. T	4. This level of care shall have sufficient staff to ensure that supportive substance use disorder services are available and responsive to the needs of the individual.
	2. S. T. S.	Services shall ensure referrals for individual to individual, group/family counseling and self-help groups. The service shall maintain a focus on the development and improvement of the skills necessary for recovery. Such services that can also be utilized through Community Resources referrals include but not limited to:
Clinical		a. Vocational services;
Operations		b. Job skills dalfillig, and employment readiness dalfillig, c. Educational; and
		d. Social skills training.
	4. rc	Individuals shall engage in aftercare services at least once a week. Random individual drug screens as needed
		All applicable ASO, ANSA, and other DBHDD reporting requirements must be met.
Billing and	2. E	
Reporting		services including amount spent, number of units occupied, and number of individuals served.
Requirements	რ თ	Span billing may occur for this service, meaning the start and end date are not the same on a given service claim line; however, spans cannot cross months (e.g.
	3)	start date and end date must be within the same month).
	←.	The organization must develop and maintain sufficient written documentation to support the services for which billing is submitted. This documentation, at a minimum, must confirm that the individual for whom billing is requested was enrolled in the Independent AD Residential Services on the billing date and that
	_	residential contact and support services are being provided at least once per week. The individual's record must also include each week's programming/service
		schedule in order to document the provision of the personal support activities.
	2.	Weekly progress notes must be entered in the individual's record to enable the monitoring of the individual's progress toward recovery goals and to reflect the
Documentation		Individualized Recovery Plan implementation. The individual's record should include health issues or concerns and how they are being addressed, appointments
Requirements	4 -	for psychiatric and medical care that are scheduled for the individual, attendance at other treatments such as substance use disorder counseling that staff may be
		assisting the individual to attend, assistance provided to the individual to help him or her reach recovery goals and the individual's participation in other recovery
		activities.
		Each note must be signed and dated and must include the professional designation of the individual making the entry.
	4 -	Documentation must be legible and concise and include the printed name and the signature of the treating practitioner. The name, title, and credentials of the
		individual providing the service must reflect the staffing requirements established for Independent AD Residential Services being delivered.
	5. F	Providers are required to have a qualifying verified diagnosis present in the individual's case record prior to the initiation of services.

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Residential:	Residential: Independent MH Residential Services	
Admission Criteria	 Individual must meet target population as indicated above; and Individual demonstrates ability to live with minimal supports; and Individual, states a preference to live independently. 	
Continuing Stay Criteria	Individual continues to benefit from and require minimal community supports.	Cas
Discharge Criteria	1. Individual, or appropriate legal representative, no longer desires service, or 2. Individual no longer meets program and/or housing criteria.	se 1:
Clinical Exclusions	Individuals with the following conditions are excluded from admission unless there is documented evidence of a psychiatric condition: Developmental Disability, Autism, Neurocognitive Disorder, or Traumatic Brain Injury.	16-c
		v-03088-E
Required Components	 Services must be provided at a time that accommodates individuals' needs, which may include during evenings, weekends, and holidays. This service requires a minimum of 1 face-to-face contact with the individual in their home each week (see also D. for an exception). Independent Residential Services may only be provided within a supportive housing program or within the individual's own apartment or home. There must be a written Residential Crisis Response Plan that guides the residential provider's response to an individual's crisis episode while receiving residential services that diverts the loss of housing and promotes housing stability. This plan shall be developed in partnership with the individual and offer 24/7 access to a residential services specialist in the event of a crisis. 	ELR Docun
Staffing Requirements	 Residential Managers may be persons with at least 2 years' experience providing MH or AD services and with at least a high school diploma; however, this person must be supervised by a licensed staff member (including LMSW, AMFT, APC or 4-year RN). Persons with high school diplomas, GEDs, or higher degrees may provide direct support services under the supervision of a Residential Manager. A staff person must be available 24/7 to respond to emergency calls within one hour. A minimum of one staff per 35 individuals may not be exceeded. 	nent 448-73
Clinical	 The organization must have a written description of the Independent Residential Service offered that includes, at a minimum, the purpose of the service; the intended population to be served; service philosophy/model; level of supervision and oversight provided; and outcome expectations for its residents. The focus of service is to view each individual as the director of his/her own recovery; to promote the value of self-help and peer support; to promote social skills, community resources, and individual advocacy; to promote employment and education to foster self-determination and career advancement; to support each individual in using community resources to replace the resources of the mental health system no longer needed; to support each individual to fully integrate into scattered site residential placement or in housing of his or her choice; and to provide necessary support assistance to the individual that furthers recovery goals, including transportation to appointments and community activities that promote recovery. The goal of this service is to fully integrate the individual into an accepting community in the least intrusive environment that promotes housing of his/her choice. 	Filed 11/29/23
	 4. The outcomes of this service will focus on recovery, housing, employment and meaningful life in the community. These outcomes will be measured based upon: a. Reduction in hospitalizations; b. Reduction in incarcerations; c. Maintenance of housing stability; d. Participation in education, vocational training or gainful employment, if this is a goal in the Individualized Recovery plan; e. Participation in community meetings and other social and recreational activities; and f. Participation in activities that promote recovery and community integration. 	Page 307 of 627

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Tier 1/Tier 2 or Private psychiatrist and Specialty services; however, individuals served shall not lose this support as a result of his/her choice to opt out of other behavioral health support/treatment services (unless these services are otherwise required by a federal program/fund source supporting a specific individual). 1. All applicable ASO and other DBHDD reporting requirements must be met.	C
rt developed by DBHDD that identifies the actual utilization of independent residential individuals served.	Case
3. Span billing may occur for this service, meaning the start and end date are not the same on a given service claim line; however, spans cannot cross months (e.g., start date and end date must be within the same month).	1:16
1. The organization must develop and maintain sufficient written documentation to support the services for which billing is submitted. This documentation, at a minimum, must confirm that the individual for whom billing is requested was enrolled in the Independent Residential Services on the billing date and that residential	-cv-C
contact and support services are being provided at least once per week. The individual's record must also include each week's programming/service schedule in order to document the provision of the personal support activities.	308
 Providers must provide documentation that demonstrates compliance with a minimum of 1 face-to-face contact per week, which includes date and time in/time out. Weekly progress notes must be entered in the individual's record to enable the monitoring of the individual's progress toward recovery goals and to reflect the 	8-ELI
Individualized Recovery Plan implementation. The individual's record should include health issues or concerns and how they are being addressed, appointments for psychiatric and medical care that are scheduled for the individual, attendance at other treatments such as substance use disorder counseling that staff may be	R
assisting the individual to attend, assistance provided to the individual to help him or her reach recovery goals and the individual's participation in other recovery activities.	Docı
4. Each note must be signed and dated and must include the professional designation of the individual making the entry.	um
Documentation must be legible and concise and include the printed name and the signature of the treating practitioner. The name, title, and credentials of the individual providing the service must reflect the staffing requirements established for Independent Residential Services being delivered.	ent 4
	148-7
ntensive AD Residential Services	3

Documentation Requirements

Residential: Independent MH Residential Services

Service Access

Billing and Reporting Requirements

Residential: I	Residential: Intensive AD Residential Services	Servic	es										
Transaction Code	Code Detail	Code	Mod 1	Mod Mod 2	Mod 3	Mod 4	Rate	Code Detail	Code Mod Mod Mod	lod M	M od	od Mod 4	Rate
Supported Housing	Addictive Diseases	H0043	生	R3									
Unit Value	Unit= 1 day							Utilization Criteria	ANSA: TBD, ASAM Level 3.5	D, ASAM	Level 3	5	
	AD Intensive Residential Service (associated with ASAM Level 3.5) provides a planned regimen of 24-hour observation, monitoring, treatment and recovery supports	(associate	ed with ≠	ASAMLe	vel 3.5)	provides	a planned	regimen of 24-hour observation	, monitorir	ig, treatn	nent and	recovery s	npports
Service	utilizing a multi-disciplinary staff for individuals who	or individu	als who	require a	a suppor	tive and	structured	require a supportive and structured environment due to a Substance Use Disorder. This Intensive level of	Use Diso	rder. Thi	is Intens	ve level of	
Definition	Residential Service maintains a basic rehabilitative	asic rehal	bilitative	focus or	n early re	covery s	kills; incluc	focus on early recovery skills; including the negative impact of substances, tools for developing support, and	ances, toc	ols for de	veloping	support, a	pu
	relapse prevention skills.												
	Adults aged 18 or older who meet the following criteria	t the follow	ing crite	ria:									
	1. The individual meets the diagnostic criteria for a Substance Use Disorder as defined in the most recent DSM.	nostic crite	ria for a	Substan	ce Use E	Disorder 8	as defined	in the most recent DSM.					
	2. The individual has sufficient or	ognitive ab	ility at th	is time to	benefit	from adr	mission to	The individual has sufficient cognitive ability at this time to benefit from admission to a residential treatment program.					
Admission	3. The individual exhibits a patter	rn of sever	e substa	ance use,	/depende	ency as (evidenced	The individual exhibits a pattern of severe substance use/dependency as evidenced by significant impairment in social, family, scholastic or occupational functioning	ıl, family, s	cholastic	or occu	pational fu	ctioning
Criteria	and one or more of the following:	wing:											
	a. The individual has not do	emonstrate	ed an ak	vility to pa	articipate	in or be	successful	a. The individual has not demonstrated an ability to participate in or be successful with less intensive levels of care as indicated by a history of prior treatment	as indicat	ed by a h	history o	prior treat	nent
	followed by rapid or severe relapse or demonstrated an inability to complete outpatient treatment.	ere relaps	e or dem	onstrate	d an inat	bility to co	omplete ou	tpatient treatment.					
	b. Individual does not have	or has no	of demor	strated to	he ability	, to utilize	e the skills	b. Individual does not have or has not demonstrated the ability to utilize the skills needed to prevent continued use, with imminently dangerous consequences.	, with imm	inently da	angerou	s consedue	nces.

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idential: II	Kesidential: Intensive AD Kesidential Services	
	c. The individual is residing in a dangerous, unstable, or otherwise unsuitable environment which would undermine effective rehabilitation treatment at a lower	
	level of care.	
	d. There is clinical evidence that the individual is not likely to respond to a lower level of care.	
yoto Scina		Ca
Continuing stay Criteria	the individual is making progress but has not yet achieved the goals in the treatmentservice plan of new problems have been identified that are appropriately treated with this level of care.	ase
	3. A timeline for expected implementation and completion is in place but discharge criteria have not been met.	1::
	The individual has accomplished the goals and objectives of the treatment/service plan; or	16-
	The individual refuses further care; or	·CV
Discharge	Individual can effectively and safely be transitioned to a lower level of care; or	-0
Criteria	The individual will be referred to other appropriate treatment which cannot be provided with this level of care; or	30
	5. The individual has received maximum benefit from this level of care; or 6. The individual's hebavior is disminifive to the treatment of others and/or fails to comply with the program miles and therapentic interventions that have not been	88-
	successful in resolving the issues.	EL
	Exhibits behavior dangerous to staff, self, or others; or	R
Clinical	The individual is experiencing symptoms which appear to require withdrawal management services.	
Fychisions	of care and can be effectively treated with that level of care.	Do
0100	Individuals with the following conditions are excluded from admission unless there is documented evidence of psychiatric condition: Developmental Disability,	CL
	njury.	ım
	Ing Abuse Treatment Program 290-4-2.	en
Required	Individuals receiving services must have a documented verified substance use diagnosis.	t 4
Components	The residential program must provide a structured and supported living environment 24 hours a day, 7 days a week with awake staff on-site at all times.	48
	Residential programs must offer priority admission as identified in the SAPT Block Grant-Funded Program Requirements.	-7
		3
	Staff facilitating clinical services must be licensed/credential, have cross training in addictive diseases and mental health, working within their scope of practice,	
	and knowledgeable of service interventions.	Fil
	There shall be sufficient staff available to all individuals at all times, with a minimum ratio of 10:1.	ed
Staffing	ment services.	1:
Kequirements	i ne program utilizes a muitidiscipiinary staπ tnat include a minimum of:	1/2
	a. Flogiam Director	9/2
	Electrical Countries Countries Countries	23
	Paraprofessionals	
	organization must have a written description of the Intensive Residential Service offered that includes, at a minimum, the purpose of the service; the intended	Pa
	population to be served; service philosophy/model, level of supervision and oversight provided; and outcome expectations for its residents.	ge
	are required to provide a structured therapeutic environment designed to facilitate the individual's progress toward recovery from substance use	30
Clinical	disorders.	9
Operations	num of 20 hours per week, (not including weekend activities) of treatment and recovery support clinical	of
	programming relevant to the Individual Recovery Plan. Services must be provided on-site at least rive (5) days per week. In addition to the required clinical programs, broviders must include treatment activities that strengthens living skills and promotes reintegration into the community. These activities include but are	627
		7

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Residential: In	Intens	Residential: Intensive AD Residential Services
		a. Vocational services;
		o. Job skills training, and employment readiness training;
		2. Educational; and
		J. Social skills training.
		The service shall maintain a focus on the development and improvement of the skills necessary for recovery.
	5.	Olinical services which include cognitive, behavioral and other therapies are facilitated through identified treatment interventions.
		Providers shall ensure that the individuals are provided the following;
		a. Individual Counseling.
		 Group Counseling (including therapy, psycho-educational, relapse prevention and recovery).
		3. Family Counseling/Training (including psycho- education) for Family Members.
		 Access to self-help and 12 step groups.
	7. A	At least 50% of the required 20 hours of clinical programming must be group counseling. The remaining hours may be comprised of group training, individual
		counseling, peer support, etc.
	∞. ⊡	Providers shall ensure that services are integrated with the activities/services and incorporated in the individual's service plan.
		Services and referrals shall be identified in the Individualized Service Plan.
	10. R	Random Individual Drug screens must be provided and documented.
	1. E	Each month, the provider must submit a Monthly Residential Service Report developed by DBHDD that identifies the actual utilization of intensive residential
Reporting and		services including amount spent, number of units occupied, and number of individuals served.
Billing	2. A	All applicable ASO, Adult Needs and Strengths Assessment (ANSA) and DBHDD reporting requirements must be met.
Requirements		Span billing may occur for this service, meaning the start and end date are not the same on a given service claim line; however, spans cannot cross months (e.g.
	S	start date and end date must be within the same month).
	<u>↑</u>	The organization must develop and maintain sufficient written documentation to support the Intensive AD Residential Service for which billing is made. This
	ס	documentation, at a minimum, must confirm that the individual for whom billing is requested was a resident of the Intensive Residential Service on the date of
	Ō	service. The individual's record must also include each week's programming/service schedule in order to document the provision of the required amount of skills
		training and support activities.
	2.	Weekly progress notes must be entered in the individual's record to enable the monitoring of the individual's progress toward IRP and recovery goals.
Documentation		The record should include health issues and how they are being addressed; appointments for psychiatric and medical care that are scheduled for the individual;
Requirements	B	attendance at other treatments such as addictive diseases counseling that staff may be assisting individual to attend; assistance provided to the individual to help
		him or her reach recovery goals; and the individual's participation in other recovery activities.
		Each note must be signed and dated and must include the professional designation of the individual making the entry.
	5. D	Documentation must be legible and concise and include the printed name and the signature of the service provider. The name, title, and credentials of the
		Providers are required to have a qualitying verified diagnosis present in the individual's case record prior to the initiation of services.

Document 448-73

Filed 11/29/23

Case 1:16-cv-03088-ELR

Residential: S	Residential: Semi-Independent AD Residential	sidenti		Services									
Transaction Code Code Detail	Code Detail	Code	Mod 1	Mod 2	Mod 3	Mod 4	Rate	Code Detail	Code	Mod Mod	Mod 3	Mod Ra	Ra
Supported Housing	Supported Housing Addictive Diseases	H0043 HF	生	R2									
Unit Value	Unit = 1 day							Benefit Information	TBD				

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supervision recovery. F relapse pra Adults age 1. The ir 2. The ir 3. The in functic	AD Semi-Independent Residential Services provides of coordinates on-site of off-site treatment services in conjunction with on-site recovery support programming that alignes with a supportive and structured living environment for individuals with a Substance Use Disorder. The residential setting is less restrictive with reduced
Iults a The The The fund	supervision as individuals begin to strengthen living skills and focus on creating financial, environmental, and social stability to increase the probability of long-term recovery. Residential Care maintains a basic rehabilitation focus on early recovery skills; including the negative impact of substances, tools for developing support, and relapse prevention skills.
ĘĘ,	Adults aged 18 or older must meet the following criteria: 1. The individual meets the diagnostic criteria for a Substance Use Disorder as defined in the most recent DSM. 2. The individual has sufficient cognitive ability at this time to benefit from admission to a residential treatment program.
	functioning and one or more of the following: a. The individual has demonstrated a limited ability to participate in or be successful with less intensive levels of care as indicated by a history or prior treatment. episodes, a demonstrated inability to complete outpatient treatment. b. Individual has limited recognition of the skills needed to prevent continued use, with imminently dangerous consequences.
. b	The individual is restaing in a dailgerous environment which would undertine enecate reliabilitation bearing is even or date. There is clinical evidence that the individual is not likely to respond to a lower level of care.
 The in The in 	The individual continues to meet admission criteria. The individual is making progress but has not vet achieved the goals in the treatment/service plan or new problems have been identified that are appropriately
	treated with this level of care. A timeline for expected implementation and completion is in place but discharge criteria have not been met.
1. The in 2. The in	The individual has accomplished the goals and objectives of the treatment/service plan; or The individual refuses further care; or
	The individual can effectively and safely be transitioned to a lower level of care; or
4. The in 6. The in 6. The in	The individual will be referred to other appropriate treatment which be provided with this level of care, or The individual has received maximum benefit from this level of care; or The individual's behavior is disruptive to the treatment of others and/or fails to comply with the program rules and therapeutic interventions that have not been
succe	successful in resolving the issues.
 Indivic Autisn 	Individuals with the following conditions are excluded from admission unless there is documented evidence of psychiatric condition: Developmental Disability, Autism, Neurocognitive Disorder, or Traumatic Brain Injury.
2. Exhibi	Exhibits behavior dangerous to staff, self, or others; or
	The individual is experiencing symptoms which appear to require withdrawal management services. The individual meets admission criteria for a lower level of care and can be effectively treated with that level of care.
	Facility must be licensed by the Georgia DCH/HFR under the Rules and Regulations for Drug Abuse Treatment Program 290-4-2. Individuals receiving services must have a documented verified substance use diagnosis.
	The residential program must provide a structured and supported living environment 24 hours a day, 7 days a week with awake staff on-site at all times. Residential programs must offer priority admission as identified in the SAPT Block Grant-Funded Program Requirements.
1. Provid 2. Clinica	Providers shall have a fulltime minimal Level 4 practitioner with at least 3 years' experience in addiction support responsible for the day to day operations. Clinical staff knowledgeable about substance use and mental health disorders with individuals with co-occurring diagnoses.
	Providers shall have a staff person available 24/7 to respond to emergency calls within one (1) hour Providers shall have an experienced staff person and supervised staff to ensure that services are available and responsive to the needs of each individual. There should be sufficient staff available to all individuals with a minimum ratio of 1·20

	 The organization must have a written description of the Semi-Independent Residential Service offered that includes, at a minimum, the purpose of the service; the intended population to be served; service philosophy/model, level of supervision and oversight provided; and outcome expectations for its residents. Providers are required to provide a structured therapeutic environment designed to facilitate the individual's progress toward recovery from substance use 	
	covery Services: mi-Independent Residential Services must provide recovery support programming and direct skills training support each week. These activities	Case 1
	i. Vocational service;	<u> 1:16</u>
	ii. Job skills training and employment readiness training; iii. Educational; and	cv-(
	iv. Skills training to include budgeting, shopping, nutritional/meal planning. v. Personal Support activities such as daily face to face contact with the individual by Residential Service to ensure needs are being met; supportive	<u> </u>
	counseling; crisis intervention as needed; tracking of appointments, assistance with transportation to appointments, shopping, employment, academics, recreational and support activities, and other needed supports as identified in the IRP.	8-FI
Olinical Operations	vi. Access to self-help and 12 step groups.	R
	-Si	_D(
	a. AD Semi-Independent Residential Service must coordinate and ensure that individuals enrolled in this service receives a minimum of 12 hours per week of Semi-Independent services as identified in the Individualized Resiliency Plan Providers may offer the clinical services on site if licensed appropriately and staffing	эсы
	is consistent with required practitioner levels. Conversely, providers may offer the clinical service off site in the agency's outpatient clinic if licensed	mer
	appropriately and staffing is consistent with required practitioner levels. Clinical services which include counitive behavioral and other theranies are facilitated through identified treatment interventions	n t 4.
		48 7
	I. Individual Counseling; iii Grann herany nevokoad nation ralansa pravantion and racovary).	73_
		_
	clinical programming must be group counseling. The remaining hours may be comprised of group counseling,	- ile
		d 1
	e. Providers shall ensure that services are integrated with the activities/services and incorporated in the individual's service plan.	1/2
		9/2
	dentifies the actual utilization of semi-independent	23
Reporting and		_
Billing Requirements	2. Spail billing first beaution this service, meaning the state are not the same on a given service daint line, nowever, spans cannot cross morning (e.g. start date and end date must be within the same month).	290
	nent (ANSA), and DBHDD reporting requirements must be met.	e :
	1. The organization must develop and maintain sufficient written documentation to support the AD Semi-Independent Residential Service for which billing is made. This	212
Doormentation	documentation, at a minimum, must confirm that the individual for whom billing is requested was a resident of the AD Semi-Independent Residential Service on the	of
Requirements	Weekly progress notes must be entered in the individual's record to enable the monitoring of the individual's progress toward IRP and recovery goals.	62
	3. The record should include health issues and how they are being addressed; appointments for psychiatric and medical care that are scheduled for the individual;	7
	attendance at other treatments such as mental health counseling that staff may be assisting individual to attend; assistance provided to the individual to help him or	_

Residential: Semi-Independent AD Residential Services

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Semi-Independent AD Residential Services	Reside	ntial S	ervice	Se					
her reach recovery goals; and the Individual's participal 4. Each note must be signed and dated and must include 5. Documentation must be legible and concise and include providing the service must reflect the staffing requireme 6. Providers are required to have qualifying verified diagnos 7. Progress notes must be entered in the individual's recording implementation.	and the Ind and date of and date of and date of spiple and treflect the lave qualifused in the of th	ndividual or and made or concise e staffing ying verime to indivice	l's partici nust inclu and incl g require fied diagr lual's rec	pation in Ide the pude the pude the pude the pude the pude the pude to come to en ord to en	other re rofessio orinted r stablishe sent in that	tion in other recovery activities. the professional designation of the printed name and the signets established for the AD Sersis present in the individual's rection and the monitoring of professionals.	her reach recovery goals; and the Individual's participation in other recovery activities. Each note must be signed and dated and must include the professional designation of the individual making the entry. Documentation must be legible and concise and include the printed name and the signature of the service provider. The providing the service must reflect the staffing requirements established for the AD Semi-Independent Residential Service Providers are required to have qualifying verified diagnosis present in the individual's record prior to the initiation of services. Progress notes must be entered in the individual's record to enable the monitoring of progress toward recovery goals and to implementation.	her reach recovery goals; and the Individual's participation in other recovery activities. Each note must be signed and dated and must include the professional designation of the individual making the entry. Documentation must be legible and concise and include the printed name and the signature of the service provider. The name, title, and credentials of the individual providing the service must reflect the staffing requirements established for the AD Semi-Independent Residential Service being delivered. Providers are required to have qualifying verified diagnosis present in the individual's record prior to the initiation of services. Progress notes must be entered in the individual's record to enable the monitoring of progress toward recovery goals and to reflect the Individualized Recovery Plan implementation.	Case 1:
Substance Detoxification	5								16-cv-(
Code Detail	Code	Mod 1	Mod 2	Mod 3	Mod 4	Rate	Code Detail	Code Mod Mod Mod Mod Rate	03088
	H0012					\$85.00			3-ELR D
1 day (per diem)							Utilization Criteria	TBD	ocum
Residential Substance Detoxification is an organized and volweek supervision, observation and support for individuals dumedical monitoring and/or on peer/social support and should Medication) Level III.2D to III.7D. These levels provide care fobservation and support by appropriately trained staff with an	ation is ar ind suppo ser/social). These Ik	rt for ind support vels pro- trained s	red and vividuals of and short and short wide carestall with staff with	voluntary during w uld reflec e for indi an empl	service ithdraw; a rang viduals viduals rasis on	that may I al manager e of reside whose into	be delivered by appropriately trained sent. Residential Withdrawal Manage ntial detoxification service intensities xication/withdrawal signs and symptoal support that cannot be provided by	Residential Substance Detoxification is an organized and voluntary service that may be delivered by appropriately trained staff who provide 24-hour per day, 7 days per week supervision, observation and support for individuals during withdrawal management. Residential Withdrawal Management is characterized by its emphasis on medical monitoring and/or on peer/social support and should reflect a range of residential detoxification service intensities from ASAM (American Society of Addiction Medication) Level III.2D to III.7D. These levels provide care for individuals whose intoxication/withdrawal signs and symptoms may only require 24-hour supervision, observation and support by appropriately trained staff with an emphasis on peer/social support that cannot be provided by the individual's natural support system, or	nent 448-73
that are sufficiently severe enough to require 24-hour medically monitored withdrawal mans facility with inpatient beds. All programs at these levels rely on established clinical protocols capacity of the facility and to transfer such individuals to more appropriate levels of service.	gh to requ ograms a nsfer such	uire 24-h t these la n individu	our med evels rely als to m	ically mc / on esta ore appr	initored iblished opriate	withdrawal clinical pro levels of se	management and support from medi stocols to identify individuals who are stvice.	that are sufficiently severe enough to require 24-hour medically monitored withdrawal management and support from medical and nursing professionals in a permanent facility with inpatient beds. All programs at these levels rely on established clinical protocols to identify individuals who are in need of medical services beyond the capacity of the facility and to transfer such individuals to more appropriate levels of service.	Filed
Adults/Older Adolescent: 1. Has a substance use disorder with a DSM diagnosis of either 303.00, 291.81, 291.0, 292.89, 292.0; and 2. Per (ASAM PPC-2, Dimension-1) is experiencing signs of severe withdrawal, or there is evidence (based withdrawal history, present symptoms, physical condition, and/or emotional/behavioral condition) that sev	der with a ion-1) is e symptoms	DSM dik xperienc s, physic	agnosis c sing sign al condit	of either s of seve ion, and/	303.00, ere witho or emot	291.81, 29 drawal, or t ional/beha	11.0, 292.89, 292.0; and here is evidence (based on history of vioral condition) that severe withdraw	ts/Older Adolescent: Has a substance use disorder with a DSM diagnosis of either 303.00, 291.81, 291.0, 292.89, 292.0; and Per (ASAM PPC-2, Dimension-1) is experiencing signs of severe withdrawal, or there is evidence (based on history of substance intake, age, gender, previous withdrawal history, present symptoms, physical condition, and/or emotional/behavioral condition) that severe withdrawal syndrome is imminent; and is assessed as	11/29/23

Unit Value Outpatient)

Service

(Residential Addiction Program Detoxification

Residential Substance Detoxification

Transaction

Code

Alcohol and/or Other

Drug Services; Sub-acute

Residential: Semi-Independent AD Resident

Definition	observation and support by appropriately trained staff with an emphasis on peer/social support that cannot be provided by the individual's natural support system, or
	that are sufficiently severe enough to require 24-hour medically monitored withdrawal management and support from medical and nursing professionals in a permanent
	facility with inpatient beds. All programs at these levels rely on established clinical protocols to identify individuals who are in need of medical services beyond the
	capacity of the facility and to transfer such individuals to more appropriate levels of service.
	Adults/Older Adolescent:
	1. Has a substance use disorder with a DSM diagnosis of either 303.00, 291.81, 291.0, 292.89, 292.0; and
	2. Per (ASAM PPC-2, Dimension-1) is experiencing signs of severe withdrawal, or there is evidence (based on history of substance intake, age, gender, previous
	withdrawal history, present symptoms, physical condition, and/or emotional/behavioral condition) that severe withdrawal syndrome is imminent; and is assessed as
	manageable at this level of service; and
	3. There is strong likelihood that the individual will not complete withdrawal management at another level of service and enter into continued treatment or self-help
Admission	recovery as evidenced by one of the following:
Criteria	a. Individual requires medication and has recent history of withdrawal management at a less intensive service level, marked by past and current inability to
	complete withdrawal management and enter continuing addiction treatment; individual continues to lack skills or supports to complete withdrawal
	management; or
	b. Individual has a recent history of withdrawal management at less intensive levels of service marked by inability to complete withdrawal management or
	enter into continuing addiction treatment and continues to have insufficient skills to complete withdrawal management; or
	c. Individual has co-morbid physical or emotional/behavioral condition that is manageable in a Level III.7-D setting but which increases the clinical severity of
	the withdrawal and complicates withdrawal management.

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Residential 9	Residential Substance Detoxification
Continuing Stay Criteria	Individual's withdrawal signs and symptoms are not sufficiently resolved so that the individual can be managed in a less intensive service.
Discharge Criteria	 An adequate continuing care plan has been established; and one or more of the following: Goals of the Individualized Recovery Plan have been substantially met; or Individual requests discharge and individual is not in imminent danger of harm to self or others; or Individual's signs and symptoms of withdrawal have failed to respond to treatment and have intensified (as confirmed by higher scores on the CIWA-Ar or other comparable standardized scoring system), such that transfer to a Level 4-WM withdrawal management service is indicated.
Service Exclusions	Nursing Assessment and Medication Administration (Medication administered as a part of Residential Detoxification is not to be billed as Medication Administration).
Clinical Exclusions	Concomitant medical condition and/or other behavioral health issues warrant inpatient treatment or Crisis Stabilization Unit admission.
Required Components	 This service must be licensed by DCH/HFR under the Rules and Regulations for Drug Abuse Treatment Programs, 290-4-2. A physician's order in the individual's record is required to initiate a withdrawal management regimen. Medication administration may be initiated only upon the order of a physician. Verbal orders or those initiated by a Physician's Assistant or CNS are acceptable provided they are signed by the physician within 24 hours or the next working day.
Staffing Requirements	 Services must be provided by a combination of nursing, other licensed medical staff, and other residential support under supervision of a physician. In programs that are designed to target older adolescents, staffing patterns must reflect staff expertise in the delivery of services to that age population. In addition, higher staffing ratios would be expected in these programs related to supervision.
Additional Medicaid	1. For Medicaid recipients, certain individual services may be billed to Medicaid if the individual is receiving this service as a part of a Crisis Stabilization Unit (see CSU service description for billable services).
Requirements	2. For those CSUs that bill Medicaid, the program bed capacity is limited to 16 beds.
Billing & Reporting Requirements	Span billing may occur for this service, meaning the start and end date are not the same on a given service claim line; however, spans cannot cross months (e.g. start date and end date must be within the same month).

	Rate	33.00	21.64	16.12
	Mod 4			
	Mod 3			
	Mod 2	U2	U2	U7
	Mod 1	C)	U4	U5
	Code Mod Mod Mod Mod	H0015 U3	H0015 U4 U7	H0015 U5 U7
	Code Detail	Practitioner Level 3, Out-of-Clinic	Practitioner Level 4, Out-of-Clinic	Practitioner Level 5, Out-of-Clinic
	Rate	26.40	17.72	13.20
	1od Mod Mod 2 3 4			
	Mod 3			
E	2	90	90	90
rogra	Code Mod	U3	N4	U5
atient P	Code	H0015 U3	H0015 U4	H0015 U5
Substance Abuse Intensive Outpatient Program	Code Detail	Practitioner Level 3, In-Clinic	Practitioner Level 4, In-Clinic	Practitioner Level 5, In-Clinic
Substance A	Transaction Code	Intensive Outpatient	Program	

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Continuing Stay

Criteria

Discharge

Criteria

An outpatient approach to treatment services for adults eighteen (18) years or older who require structure and support to achieve and sustain recovery, focusing on

Utilization Criteria

Substance Abuse Intensive Outpatient Program

Unit Value

Service Definition

early recovery skills; including the negative impact of substances, tools for developing support, and relapse prevention skills.

Admission

Criteria

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m rd}$ Quarter Provider Manual for Community Behavioral Health Providers (January 1, 2023)

onostance A	Substance Abuse Intensive Outpatient Program	
	1. Services cannot be offered with Psychosocial Rehabilitation-Program.	
	When offered with ACT, documentation must ind	icate efforts to minimize duplication of services and effectively transition the individual to the appropriate services.
	This combination of services is subject to review by the Administrative Service Organization (ASO).	nization (ASO).
Service	3. Service elements included within SAIOP include counseling, group outpatient services, family outpatient services, community support, and peer support programs.	ses, family outpatient services, community support, and peer support programs.
Exclusions		ovided outside of SAIOP. Any exception must be clinically justified in the medical
	record and may be subject to scrutiny by the ASO. Exceptions in offering these services external to SAIOP include scenarios where there are sensitive and targeted	ices external to SAIOP include scenarios where there are sensitive and targeted
	clinical issues to be addressed that require a specialized intervention or privacy (e.g., sexual abuse, criminal justice system involvement, etc.). When an exception	3., sexual abuse, criminal justice system involvement, etc.). When an exception
	_	
	1. This service must be licensed by DCH/HFR under the Rules and Regulations for Drug Abuse Treatment Programs, 290-4-2	ug Abuse Treatment Programs, 290-4-2.
	•	schedules as part of its operational method, i.e., plans or schedules of days or
	times of day for certain activities.	
	3. These services should be scheduled and available at least 5 hours per day, 4 day	le at least 5 hours per day, 4 days per week (20 hrs. /week), with no more than 2 consecutive days without service
	availability for high need individuals (ASAM Level 2.5). For programs that have a lower intensity program Level, it should be at least ASAM Level 2.1 which	wer intensity program Level, it should be at least ASAM Level 2.1 which
	4. The program utilizes methods, materials, settings, and outside resources appropriate to the developmental and cognitive levels, capabilities, age, gender, and	e to the developmental and cognitive levels, capabilities, age, gender, and
	5. The program utilizes methods, materials, approaches, activities, settings, and outside resources appropriate for and targeted to individuals with co-occurring	the resources appropriate for and targeted to individuals with co-occurring
	disorders of mental illness and substance use and targeted to individuals with co-occurring developmental disabilities and substance use when such individuals	courring developmental disabilities and substance use when such individuals
	are referred to the program.	
Required	6. Drug	rements but are not billable to DBHDD as components of this service benefit.
Components		s for marking participant's progress toward goals and for service planning.
SHIPLING	7.	s withdrawal management or residential services.
	8. This service must operate at an established site approved to bill Medicaid for services. However, limited individual or group activities may take place off-site in	es. However, limited individual or group activities may take place off-site in
	natural community settings as is appropriate to each individual's treatment plan. (Narcotics Anonymous (NA) and/or Alcoholics Anonymous (AA) meetings offsite	arcotics Anonymous (NA) and/or Alcoholics Anonymous (AA) meetings offsite
	may be considered part of these limited individual or group activities for billing purposes only when time limited and only when the purpose of the activity is	oses only when time limited and only when the purpose of the activity is
	introduction of the participating individual to available NA and/or AA services, groups or sponsors. NA and AA meetings occurring during the SA Intensive	s or sponsors. NA and AA meetings occurring during the SA Intensive
	Outpatient package may not be counted as billable hours for any individual outpatient services, nor may billing related to these meetings be counted beyond the	int services, nor may billing related to these meetings be counted beyond the
	basic introduction of an individual to the NA/AA e	
	9. This service may operate in the same building as other services; however, there n	other services; however, there must be a distinct separation between services in staffing, program description,
		ration.
	10. Adequate space, equipment, turnishings, supplies, and other resources must be provided in order to effectively provide services and so that the program	wided in order to effectively provide services and so that the program
		equipment, turnishings, supplies, transportation, and other resources for participating individuals use within the
		must not be substantially different from that provided for other uses for similar numbers of individuals.
	1. The program must be under the clinical supervision of an LCSW, LPC, LMFT, MAC, CAADC, GCADC-II/-III, or CAC-II, who is onsite a minimum of 50% of the	, CAADC, GCADC-II/-III, or CAC-II, who is onsite a minimum of 50% of the
	hours the service is in operation.	
Ctoffing		
Starming	. d	C-I (with Bachelor's Degree). CPS-AD (with Bachelor's Degree).
-	i	ounselor-Trainee (with Bachelor's Degree and with supervision).
	c. Level 5: Under the supervision of an LČSW, LPC, or LMFT (for SUD practitioners, an LCSW, LPC, LMFT, MAC, CAADC, GCADC-II/-III, or CAC-II)	ers, an LCSW, LPC, LMFT, MAC, CAADC, GCADC-II/-III, or CAC-II):
	Paraprofessionals (without Bachelor's Degree), GCADC-I (without Bachelor's Degree), CAC-I (without Bachelor's Degree), CPS-AD (without Bachelor's	Degree), CAC-I (without Bachelor's Degree), CPS-AD (without Bachelor's

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Case 1:16-cv-03088-ELR

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Substance Abuse Intensive Outpatient Program Degree). 3. Programs must have documentation that there is one Level 4 or above staff (excluding Certified Alcohol and Drug Counselor-Trainees) that is "co-occurring capable." This person's knowledge must go beyond basic understanding and must demonstrate actual staff capabilities in using that knowledge for individuals with co-occurring disorders. Personnel documentation should demonstrate that this staff person has received a minimum of 4 hours of training in co-occurring treatment within the past 2 years. 4. There must be at least a Level 4 or above practitioner on-site at all times the service is in operation, regardless of the number of individuals participating. 5. The maximum face-to-face ratio cannot be more than 12 individuals to 1 U3 level practitioner based on average daily attendance of individuals in the program. 6. The maximum face-to-face ratio cannot be more than 20 individuals to 1 U3 level practitioner based on average daily attendance of individuals in the program. 7. A physician and/or a Registered Nurse or a Licensed Practical Nurse with appropriate supervision must be available to the program either by a physician and/or a gency, through a contract with a licensed practitioner, or by written referral or affiliation agreement with another agency or agencies that	 a. An appropriate member of the medical staff pursuant to the Medical Practice Act of 2009, Subsection 43-34-23 Delegation of Authority to Nurse and Physician Assistant is responsible for addiction and psychiatric consultation, assessment, and care (including but not limited to ordering medications and/or laboratory testing) as needed. b. The nurse is responsible for nursing assessments, health screening, medication administration, health education, and other nursing duties as needed. 8. LPNs who provide non-nursing SAIOP supports must do so as a Paraprofessional (including completion of the STR for Paraprofessionals) in accordance with item 2c above. 9. Level 3 or 4 staff may be shared with other programs as long as they are available as required for supervision and clinical operations and as long as their time is appropriately allocated to staffing ratios for each program. 	 It is expected that the transition planning for less intensive service will begin at the onset of these services. Documentation must demonstrate this planning. An individual may have variable length of stay. The level of care should be determined as a result of the individuals' multiple assessments. It is recommended that individuals attend at a frequency appropriate to their level of need. Ongoing clinical assessment should be conducted to determine step down in level of care. a. Each individual should participate in setting individualized goals for themselves and in assessing their own skills and resources related to sobriety, use, and maintaining recovery. Goals are set by exploring strengths and needs in the individual's living, learning, social, and working environments. Provision of service may take place individually or in groups. b. Each individual must be provided assistance in the development/acquisition of needed skills and resources necessary to achieve sobriety and/or reduction in use and maintenance of recovery. 	3. The Substance Abuse Intensive Outpatient Program must offer a range of skill-building and recovery activities within the program. 4. The Substance Abuse Intensive Outpatient Program activities will include, but are not limited to, the following: a. Psycho-educational activities focusing on the disease of addiction prevention, the health consequences of addiction, and recovery b. Therapeutic group treatment and counseling c. Leisure and social skill-building activities without the use of substances	a. Linkage to natural supports and send beginnings e. Individualized treatment, service, and recovery planning g. Linkage to health care h. Family education and engagement i. AD Support Services j. Vocational readiness and support
Substan			Clinical Operations	

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	Case	1:16-cv-()3088-I	ELR	Docun	nent 44	48-73	3 Fi	led 11/29/23
Substance Abuse Intensive Outpatient Program 5. Assessment, reassessment, and medical services (included in the programmatic model, but billed as discrete services) will include: a. Behavioral Health Assessment b. Psychiatric Treatment	c. Nursing Assessment d. Diagnostic Assessment e. Medication Administration		 c. Staffing patterns for the program including access medical and evaluation staff as needed. d. How the activities listed above in Items 4 and 5 will be offered and/or made available to those individuals who need them, including how that need will be determined. 	e. How assessments will be conducted. f. How staff will be trained in the administration of addiction services and technologies. d. How staff will be trained in the recognition and treatment of co-occurring disorders of mental illness & substance use pursuant to the Georgia Bast Practices.	h. How services for individuals with co-occurring disorders will be flexible and will include services and activities addressing both mental health and substance use issues of varying intensities and dosages based on the symptoms, presenting problems, functioning, and capabilities of such individuals. i. How individuals with co-occurring disorders who cannot be served in the regular program activities will be provided and/or referred for time-limited special	integrated services that are co-occurring enhanced as reflected in <u>Guiding Principles Regarding Co-Occurring Mental Health and Addictive Diseases</u> <u>Disorders, 04-109.</u> How services will be coordinated with the substance use array of services including assuring or arranging for appropriate referrals and transitions.	k. How the requirements in these service guidelines will be met. 1. Service access to the program is offered at least 5 hours per days at least 4 days per week with no more than 2 consecutive days between offered services and	distinguishes between those individuals needing between or more of structured services per week (ASAM Level 2.5	 Program hours are to be published and distributed to all individuals served (and updated/redistributed as needed).
Subst								Service Accessibility	

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Substance Abuse Intensive Outpatient Program

- The maximum number of units that can be billed a day for SAIOP is 5 units.
- There are some outpatient services which are required components of SAIOP but because of their frequency of use, are not practical as part of the bundled services. The following are those additional services that are to be billed unbundled as part of the SAIOP program:

Service	Maximum Authorization Units	Naximum Authorization Units Daily Maximum Billable Units
Behavioral Health Assessment & Service Plan Development	32	24
Diagnostic Assessment	4	2
Psychiatric Treatment	12	_
Nursing Assessment and Care	48	16
Medication Administration	8	8
Interactive Complexity (as a modifier to Psychiatric Treatment, Diagnostic Assessment, Individual Counseling, and Group Counseling)	48	4
Community Transition Planning	09	12

- The following services are included in the SAIOP and should not be requested as part of the SAIOP authorization, nor should they be ordered separately outside of the SAIOP authorization except under special circumstances (see Service Exclusions section):
 - Family Outpatient Services (Counseling & Training)

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Requirements Reporting Billing &

- Group Outpatient Services (Counseling & Training)
 - Individual Counseling
- Addictive Disease Support Services
- AD Peer Support Program ö
- break for lunch, his/her participating hours are 3.75 hours. The rounding policy is applied to the .75 hour and the units billed for that day are 4 units. Practitioner type Rounding is applied to the person's cumulative hours/day at the Substance Abuse Intensive Outpatient Program (excluding non-programmatic time). The provider must still be addressed and so those 4 units must be adequately assigned to either a U3, U4 or U5 practitioner type as reflected in the log for that day's activities. shall follow the guidance in the rounding policy included in this Provider Manual, and, specific to this service, the person served must have participated in at least 50% of the hour in order to bill for one unit of this service. For instance, if an individual participates in the program from 9:00 am -1:15 pm excluding a 30-minute 4
 - each service. Program expectations are that this model follow the content of this Service Guideline as well as the clearly defined service group elements. Approved providers of this service may submit claims/encounters for the unbundled services listed in the package, up to the daily maximum amount for 5
- the designated programmatic hours or needs services other than the designated programmatic services, AND the provider is enrolled to provide those services, the Services authorized via the SAIOP Type of Care are only billable during the designated programmatic hours. If an individual needs additional service time outside services are to be separately ordered and authorized (for example, services through the Non-Intensive Outpatient Type of Care) <u>ن</u>

3. Progress notes must include written daily documentation of groups, important on goals identified in the IRP including acknowledgement of addiction, progress	en daily d	ocume	ntation yement	of grou	ps, importion, pi	ogress tov	rrences; level of functioning; acquisitic vard recovery, use, reduction and/or a	Progress notes must include written daily documentation of groups, important occurrences; level of functioning; acquisition of skills necessary for recovery; progress on goals identified in the IRP including acknowledgement of addiction, progress toward recovery, use, reduction and/or abstinence; use of drug screening results by	Ca
4. Provider shall only document and bill units in service delivered. Should an individual leave	ectivenes bill units idual leav	ss. in whicl re the p	h the in rogram	ıdividua ı or rece	l was ac sive othe	tively enga er services	iged in services. Meals and breaks mi during the range of documented time	start; and evaluation of service effectiveness. Provider shall only document and bill units in which the individual was actively engaged in services. Meals and breaks must not be included in the reporting of units of service delivered. Should an individual leave the program or receive other services during the range of documented time in/time out for SAIOP hours, the absence	ase 1:1
should be documented. 5. Daily attendance of each individua 6. Program hours are to be published	al particip d and up	ating in dated a	the pro s need	ogram r ed in th	nust be e progra	documente ım's admin	ed showing the number of hours in attentive record so as to be available t	should be documented. 5. Daily attendance of each individual participating in the program must be documented showing the number of hours in attendance for billing purposes. 6. Program hours are to be published and updated as needed in the program's administrative record so as to be available to any external reviewers to validate billing	6-cv-03
7. This service may be offered in conjunction with ACT or CSU for a limited time to tran 8. When this service is used in conjunction with ACT or Crisis Residential services, doc this service as well as an appropriate reduction in service amounts of the service to these services is subject to review by the Administrative Service Organization (ASO)	onjunctior unction v riate redu w by the	with A vith AC vith AC scrion ir Adminis	CT or (T or Cri servicestratives	CSU for isis Res e amou Service	a limite idential nts of th	d time to tr services, d le service t zation (AS	This service may be offered in conjunction with ACT or CSU for a limited time to transition individuals from one service to the more appropriate one. When this service is used in conjunction with ACT or Crisis Residential services, documentation must demonstrate careful planning to maximize the this service as well as an appropriate reduction in service amounts of the service to be discontinued. Utilization of Substance use Day services in cothese services is subject to review by the Administrative Service Organization (ASO).	This service may be offered in conjunction with ACT or CSU for a limited time to transition individuals from one service to the more appropriate one. When this service is used in conjunction with ACT or Crisis Residential services, documentation must demonstrate careful planning to maximize the effectiveness of this service as well as an appropriate reduction in service amounts of the service to be discontinued. Utilization of Substance use Day services in conjunction with these services is subject to review by the Administrative Service Organization (ASO).	8088-ELR
Employment									Docu
Code Detail Co	Code Ma	Mod N	Mod 2	Mod 3	Mod 4	Rate	Code Detail	Code Mod Mod Mod Mod Rate	ment
H2	H2024					\$410.00			: 448
1 month - Weekly documentation via daily attendance or weekly	laily atten	dance o	r weekl	ly time sheet.	heet.		Utilization Criteria	TBD	-73
Supported Employment (SE) services Plan (IRP); and who, due to the impar	s are ava	ilable to	eligibl	e indivi	duals, w	ho express ave recent	s a desire and have a goal for competion lost employment, or been underem	Supported Employment (SE) services are available to eligible individuals, who express a desire and have a goal for competitive employment in their Individual Recovery Plan (IRP): and who, due to the impact and severity of their mental illness have recently lost employment, or been underemployed or unemployed on a frequent or long-	3
term basis. Services include supports	s to acces	ss bene	fits cou	Inseling	; identify	/ vocationa	Il skills and interests; and develop and	term basis. Services include supports to access benefits counseling; identify vocational skills and interests; and develop and implement a job search plan to obtain	File
practice, this service emphasizes than	it a rapid	job sea	rch be	prioritiz	ed abov	e traditiona	udal s su eriguis, preferences, admines Il prevocational training, work adjustm	practice, this service emphasizes that a rapid job search be prioritized above traditional prevocational training, work adjustment, or transitional employment services.	d 11,
After suitable employment is attained teach the individual illness self-manace	I, service: gement, (s includ	e job c nicatior	oacning ה and in	j to teac terpersc	n job-speci nal skills r	nc skilis/tasks required for job perforn iecessary to successfully retain a part	After suitable employment is attained, services include job coaching to teach job-specific skills/rasks required for job performance and ongoing renabilitative supports to teach the individual illness self-management, communication and interpersonal skills necessary to successfully retain a particular job. If the individual is terminated or	/29/
desires a different job, services are provided to assist the indi- employment aligned with these goals. Employment goals and	rovided to Employ	o assist ment ox	the inc	d servic	in redef	ining vocat ntegrated i	ional and long-term career goals and note the Individual Recovery Plan (IRP	desires a different job, services are provided to assist the individual in redefining vocational and long-term career goals and in finding, learning and maintaining new employment aligned with these goals. Employment goals and services are integrated into the Individual Recovery Plan (IRP) and are available until the individual no	23
longer desires or needs Supported Employment Specialty Services to successfully maintain employment.	mployme	nt Spec	ialty So		to succe	essfully ma	intain employment.		Р
 Individuals who meet the target population criteria: Indicate an interest in competitive employment: 	opulation ompetitive	n criteria	a: vment:						age
b. Are unemployed or unde	eremploy	enp pe	to sym	ptoms a	ssociate	ed with chr	Are unemployed or underemployed due to symptoms associated with chronic and severe mental illness;		32
 c. Have a documented service goal to attain and/or maintain competitive employment; and d. Are able to actively participate in and benefit from these services 	vice goal	to attai	n and/c nefit fro	or maini om thes	ain com	petitive en	րloyment; and		of C
Priority	o meet th	ne ADA	Settler	nent cri	teria.	i			62
3. Individuals receiving this service must have a qualifying diagnosis present in the	must hav	ve a qui	alifying	diagno	sis pres	ent in the n	nedical record prior to the initiation of	Individuals receiving this service must have a qualifying diagnosis present in the medical record prior to the initiation of services. The diagnosis must be provided by	7
persons identified III O.C.G.A. P.	acilce Al	א מש	nallier) () () ()	וחב מ חו	agiiosis.			

2. Daily notes must include time in/time out in order to justify units being utilized.

Documentation Requirements

Every admission and assessment must be documented.

Substance Abuse Intensive Outpatient Program

Supported	Supported Employment												
Transaction Code	Code Detail	Code	Mod 1	Mod 2	Mod 3	Mod 4	Rate	Code Detail	Code	Mod 1	Mod 2	Mod Mod Mod Mod	l Rate
Supported Employment		H2024					\$410.00						
Unit Value	1 month - Weekly documentation via daily attendance or weekly time sheet.	via daily at	tendance	or week	ly time sh	neet.		Utilization Criteria	TBD				
	Supported Employment (SE) ser	vices are	available	to eligibl	e individ	uals, wh	o express	Supported Employment (SE) services are available to eligible individuals, who express a desire and have a goal for competitive employment in their Individual Recovery	itive empl	yment	in their	Individual	Recovery
	Plan (IRP); and who, due to the in	mpact and	d severity	of their	mental il	Iness ha	ive recently	Plan (IRP); and who, due to the impact and severity of their mental illness have recently lost employment, or been underemployed or unemployed on a frequent or long- term basis. Services include supports to access benefits connealing: identify vocational skills and interests: and develop and implement a job search plan to obtain	ployed or I impleme	unemplo nt a joh	oyed or search	a frequer	t or long- tain
	competitive employment in an interest	egrated o	ommunity	setting	that is b	ased on	the individ	competitive employment in an integrated community setting that is based on the individual's strengths, preferences, abilities, and needs. In accordance with current best	, and nee	ds. In ac	cordar	ce with cu	rrent best
Service	practice, this service emphasizes	that a ray	es doj bic	arch be	prioritize	d above	traditional	practice, this service emphasizes that a rapid job search be prioritized above traditional prevocational training, work adjustment, or transitional employment services	ent, or tra	nsitiona	al emplo	yment ser	vices.
Definition	After suitable employment is attai	ined, serv	ices inclu	de job c	oaching	to teach	job-specif	After suitable employment is attained, services include job coaching to teach job-specific skills/tasks required for job performance and ongoing rehabilitative supports to	nance and	ongoin	g rehat	ilitative su	pports to
	teach the individual illness self-m	anageme	nt, comn	unication	and int and	erpersor	nal skills ne	teach the individual illness self-management, communication and interpersonal skills necessary to successfully retain a particular job. If the individual is terminated or	icular job.	If the in	dividua	l is termin	ated or
	desires a different job, services a	re provide	ed to assi	st the inc	dividual i	n redefir	ing vocation	desires a different job, services are provided to assist the individual in redefining vocational and long-term career goals and in finding, learning and maintaining new	in finding,	learnin	g and n	ıaintaining	new
	employment aligned with these g	oals. Emp	loyment	goals an	d service	es are in	tegrated ir.	employment aligned with these goals. Employment goals and services are integrated into the Individual Recovery Plan (IRP) and are available until the individual no) and are	availabl	e until 1	he individ	ıal no
	Innger desires or needs Supported Employment Specialty Services to successfully maintain employment.	3d Employ	ment Sp	ecialty S	ervices t	o succe	ssfully mai.	intain employment.					
	1. Individuals who meet the target population criteria	net popula	tion crite	<u>'ä</u> .									
	a. Indicate an interest in competitive employment;	in compet	itive emp	loyment;									
	b. Are unemployed or u	underemp	loyed du	e to sym	ptoms as	ssociate	d with chro	. Are unemployed or underemployed due to symptoms associated with chronic and severe mental illness;					
Admission	c. Have a documented service goal to attain and/or maintain competitive employment; and	service g	oal to att	ain and/c	or mainte	ain comp	etitive em	ployment; and					
Criteria	 d. Are able to actively participate in and benefit from these services. 	oarticipate	in and b	enefit frc	om these	service	S.						
	2. Priority is given to individuals who meet the ADA Settlement criteria.	s who mee	∍t the AD	A Settler	nent crit	eria.							
	3. Individuals receiving this ser	vice must	have a q	ualifying	diagnos	is prese	nt in the m	Individuals receiving this service must have a qualifying diagnosis present in the medical record prior to the initiation of services. The diagnosis must be provided by	services.	The dia	gnosis ı	nust be pr	ovided by
	persons identified in O.C.G.A. Practice Acts as qualified to provide a diagnosis.	4. Practice	e Acts as	qualifiec	to provi	de a dia	gnosis.						

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 Supported Employment Employment must be in an integrated community setting in which the majority of employees do not have disabilities, and there is no requirement for the applicant to have a disability. The job must pay minimum wage or equivalent to typical earnings/benefits for the job title and be in compliance with all applicable Department of Labor requirements, including compensation, hours, and benefits. 5. If ACT, CST, Non-Intensive Outpatient, PSR-I, Peer Supports other behavioral health and/or vocational revoires are provided simultaneously, individual record must show evidence of integrated service coordination and effort to avoid duplication of services. 6. A vocational profile, individualized plan of employment and show evidence of periodic updates. If an individual's strengths and profile profile must be included in the individual's behavioral service record. 7. The initial vocational profile must be completed and the individual's behavioral behavioral profile in dividual's plan of employment, on average, within the first 30 days of individual's enrollment in SE services and be documented in the progress notes. 	 Individuals receiving this service must have competitive employment as a goal in their IRP. Ninety percent (90%) of Individual medical records must demonstrate integration of behavioral health and employment goals and services. Charts of individuals who have open cases in Vocational Rehabilitation services must document fulfillment of Vocational Rehabilitation meeting, reporting and communication requirements. Supported Employment Specialists must deliver each of the following six service components: 	i. Engage individual, and with permission, his/her behavioral health providers and natural supports in an exploratory discussion about the individual's interest in competitive employment and long-term vocational goals. Provide or coordinate access to information about vocational services offered by GVRA/VR; and according to the individual's desires and GVRA/VR guidelines, assist and support the individual in completion and coordination of the GVRA/VR application process and regular follow-up communication with GVRA/VR staff to determine status of application. ii. Determine if the individual receives SSI, SSDI or other benefits which might be affected by an increase in income and provide or coordinate access to informational resources about work incentives and benefits counseling. Ensure that the individual and with permission, his/her behavioral health providers and natural supports receive and understand individualized and written information about how new or increased wages will impact the individual's eligibility for and receipt of disability benefits, housing and/or other income-determined services and benefits, as well as	how to complete any related and required financial reports. Over several sessions, gather information from individual, and with permission, his/her behavioral health providers, Vocational Rehabilitation Counselor, natural supports, former employers, and/or existing records/reports to develop a vocational profile that provides insight to the individual's preferences, experiences, abilities, strengths, supports, resources, limitations and needs. Engage the individual, and if desired, his/her professional and/or natural supports in a discussion about his/her vocational profile to explore, identify and document desirable and suitable job types and work environments. Ensure the Vocational Profile is integrated into the individual's behavioral health service chart. Educate individual about the pros and cons of disclosing aspects of his/her disability and discuss at frequent intervals to support and empower the individual to make informed decisions about what, if any details s/he wants communicated to the employer at any point in time.	 b. Service Integration: Provide direct or indirect efforts on behalf of the individual to integrate, coordinate and reduce duplication of the individual's SE service with TORS and other behavioral health and if applicable, Vocational Rehabilitation or other pertinent services, through regular, documented meetings and contact with members of the individual's multidisciplinary treatment team. c. Job Development: Cultivate relationships with potential employers in order to explore and develop competitive employment appropriate and employment plans for individuals. Competitive employment refers to a job to which anyone can apply, in an integrated community setting in which the majority of employees are not disabled, and which pays minimum wage or more. Relationships are to be based on an understanding of the potential employer's business needs; the services the Employment Specialist is able to provide to the company; and the employment plans of individuals served. Employer contacts should be documented weekly and reviewed regularly by the SE Supervisor according to IPS-25 model. D. Job Placement
Support			Clinical Operations	

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Supported Employment	mployment	
	i. Develop with the individual, and with permission, his/her behavioral health provider, VR Counselor and/or natural supports an individual plan of employment which includes the type of job and environment being sought, the type of supports the individual wants and clear statements about who will	
	ii. Teach, assist and support the individual to emphasize strengths and minimize consequences (i.e., criminal history, periods of unemployment, etc.) and functional challenges of mental illness in development of resumes, completion of applications and practice for interviews (which may include symptom	Case
	ing a mutually acceptable job offer in a competitive, community-integrated job that meets the individual's vocational goals produced and/or adaptations to ensure the individual's success in the work environment.	21:16
		6-cv-0
	days on the job. The plan may include assistance in symptom management, acquiring appropriate work clothes and transportation to work; as well as planning for meals, medication and other activities and supports needed to maintain wellness and stability at the work site. The individual's chart should contain this plan.	3088-I
		ELR
	e. Job Coacning: Provide intensive one-on-one services designed to teach the individual job-specific skills, tasks, responsibilities and benaviors on or on the individual's disclosure preferences. This may include systematic job analysis, environmental assessment, vocational counseling, training and interventions to help the supported employee learn to perform job tasks to the employer's specifications and be accepted as an employee at the	Docu
	worksite. Provide training, consultation and support to the employer at the individual's request. f. Follow-Along Supports	ımer
	i. Work in partnership with the individual and his/her behavioral health providers, Vocational Rehabilitation Counselor and/or natural supports to update and implement an individualized job support plan that maximizes the use of natural supports and prepares the individual and his/her	nt 44
	interdisciplinary treatment, rehabilitation and recovery teams for transition to extended job supports provided by behavioral health providers and/or natural supports. Provide and coordinate ongoing task-oriented rehabilitation and job-specific training and support for management of symptoms,	8-73
	crises and over-all job performance necessary for long term success, tenure and stability on the job. Per individual's preferences about disclosure, services may include proactive employment advocacy, supportive counseling, coaching, peer support and ancillary support services. at or away	F
	from the job site. Employment Specialist must make a minimum of 2 face-to-face visits with supported employee at the worksite each month: or 2 face-to-face visits	iled
		11/
	1. A monthly, standardized programmatic report is required by the DBHDD to monitor performance and outcomes as well as approve the amount requested via the MIERs.	29/2
	ns are expected to submit all requisite information in order to establish eligibility for the initial authorization, and if an individual meets eligibility they receive as a uthorization for SE services. SE teams are required to submit information that the ASO references as a reauthorization every 90-days for collection of	3
Reporting and Billing		Page
Requirements	merely a data collection process and not a clinical review for eligibility every 90 days. SE teams are	32
	expected to subtrict an requisite mijorniation in order to establish continued engionity for the concurrent leview, and this readinionzation finite marriers for days.	3 of
	3. In order to bill the monthly rate, the provider shall be engaged in supports and planning even when individual is in acute residential, hospital or jail. See discharge criteria #4.	627

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Supported	Supported Employment	
	4. If a provider has no face-to-face contact with the individual during the month, the monthly rate may be billed if the provider has documentation of service integration, job development or active participation in discharge planning if the individual is in acute residential, hospital or jail. See discharge criteria #4.	
	5. Span billing may occur for this service, meaning the start and end date are not the same on a given service claim line; however, spans cannot cross months (e.g.	(
	6. DBHDD providers of adult mental health Individual Placement and Support (IPS) Supported Employment (SE) are required to deliver TORS for all Medicaid-eligible persons.	Case
Service Accessibility	Employment Specialists are expected to spend at least 65% of scheduled work time delivering services to individuals and employers in the community and must be available during daytime, evening and weekend hours to accommodate the needs of individuals and employers.	1:16-
Documentation Requirements	 The individual medical record must include documentation of services described in the Service Operations section. Provider is required to complete a progress note for every contact with individual as well as for related collateral. Progress notes must adhere to documentation requirements set forth in this manual. 	cv-0308
i F	(300±/ 500±/	8-ELF
ask-Orlen	ask-Oriented Kenabilitation Services (10Ks)	₹

action														
Code	Code Detail	Code	Mod 1	Mod	Mod 3	Mod 4	Rate	Code Detail	Code	Mod 1	Mod 2	Mod 3	Mod F	Rate
Task- Oriented	Practitioner Level 4, In-Clinic	H2025	U4	90			\$20.30	Practitioner Level 5, In-Clinic	H2025	US	90		0,7	\$15.13
	Practitioner Level 4, Out-of-Clinic	H2025	U4	U7			\$24.36	Practitioner Level 5, Out-of- Clinic	H2025	US	U7		0,7	\$18.15
Unit Value 15	15 minutes							Utilization Criteria	OBT					
Te wiw	Task Oriented Rehabilitation Services (TORS) provide the psychiatric rehabilitation interventions to address the barriers created by psychiatric disability that interfere with an individual's ability to develop or regain a meaningful and valued role, including the ability to successfully pursue and maintain satisfying competitive employment.	or regain	provide a mean	the psy ingful ar	/chiatric	rehabilit d role, ir	ation interval	entions to address the barriers cre ability to successfully pursue and	ated by p maintair	osychiat n satisfyi	ric disak ing com	oility that petitive	interfe employr	re nent.
2 0	TORS are delivered concurrently with and arief discharge from evidence-based supported employment services (IPS-25), <u>muss/missorial</u>) in the workship of community, in accordance with an individual's preferences about disclosure of his/her disability to employers. TORS must be based upon the Individual Recovery Plan	n and alle dividual's p	r discriz preferer	nge nor	n eviden out discl	osure of	d supporte his/her disa	rarge from evidence-based supported employment services (if 5-25), <u>mitos/inpsworks.org/</u> in the worksite of ences about disclosure of his/her disability to employers. TORS must be based upon the Individual Recovery	e based	upon th	e Individ	e worksi dual Rec	te or overy P	lan
H) Peq	(IRP) which identifies a desire and need to acquire the skills, resources and supports the individual needs to self-recognize emotional triggers and to self-manage behaviors related to behavioral health issues that may interfere with employment.	eed to acq h issues th	luire the nat may	skills, r interfer	esource e with er	ક and ડા mploym	upports the ent.	individual needs to self-recognize	emotiona	al triggeı	s and to	o self-ma	anage	
	TORS goals must complement and be closely coordinated with the goals, plans, and activities of supported employment, behavioral health and other services and integrated into the Individualized Recovery Plan (IRP). Interventions may include: 1. The use of role-modeling or mentoring of a person working while managing a mental illness:	be closely sovery Plantoring of a	coordin n (IRP). 1 persor	ated wit Interve	h the go entions n	als, plar nay inclu managin	ns, and activude:	vities of supported employment, be illness;	shavioral	health a	and othe	er service	es and	
Definition 2.	. Motivational and educational experiences, exercises, methods and tools to help an individual: a. Develop hope, confidence and motivation related to a meaningful and valued role incl	periences, ce and mo	exercis tivation	ses, met related	hods an to a me	nd tools t aningful	o help an ir and valuec	onal and educational experiences, exercises, methods and tools to help an individual: Develop hope, confidence and motivation related to a meaningful and valued role including employment.						
	 b. Identify, articulate and self-advocate for c. Identify and engage natural supporters 	self-advoce ural suppo	ate for h	is/her gr assist ir	oals, intena	erests, s ing his/h	kills, streng ner vocation	his/her goals, interests, skills, strengths, needs and preferences; to assist in achieving his/her vocational & recovery goals;						
	d. Identify and develop meaningful roles while living with a mental illness;	aningful rc	oles whi	le living	with a n	nental ill	ness;							
	e. Identify consequences o	of increase	d incon	ne, deve	lop and	use a p	lan to mane	Identify consequences of increased income, develop and use a plan to manage these consequences in manner that supports the individual's preferences	r that sup	oports th	ie indivi	dual's pi	referenc	ses
	and attainment of recovery, financial and vocational goals; and	ery, financ	ial and	vocation	nal goals	s; and								
	 Use recovery, wellness and symenaged in vocational activities. 	and symp	tom ma	nageme	ent plans	s, coping	skills and (Use recovery, wellness and symptom management plans, coping skills and strategies to manage mental health needs and challenges that may arise while engaged in vocational activities.	needs a	and chal	lenges i	that may	, arise v	/hile

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	Individuals receiving evidence-based supported employment services (IPS-25) are eligible to enroll in TORS and may continue receiving TORS if they are competitively employed at the time of discharge from supported employment services and do not meet discharge criteria.
Admission Criteria	 Individual must meet DBHDD Eligibility criteria; and Aave a goal for competitive employment in his/her Individual Recovery Plan (IRP); Be enrolled in supported employment services; and C. Need psychiatric rehabilitation services to address the barriers created by their psychiatric disability that interfere with the individual's ability to develop or regain a meaningful and valued role including the ability to successfully pursue and maintain satisfying competitive employment. Priority is given to individuals who meet the ADA Settlement criteria; Individuals receiving this service must have a qualifying diagnosis present in the medical record prior to the initiation of services. The diagnosis must be provided by persons identified in O.C.G.A. Practice Acts as qualified to provide a diagnosis.
Continuing Stay Criteria	 Individual demonstrates documented progress relative to identified TORS goals but goals have not yet been achieved, and: a. Is enrolled in evidence-based supported employment services; or b. Is competitively employed but no longer needs and therefore has been discharged from evidence-based supported employment provider If the individual has no behavioral health providers other than a psychiatrist, the individual may receive extended TORS from his/her supported employment. if s/he is competitively employed at the time of supported employment discharge and needs these services to maintain his/her goal of competitive employment.
Discharge Criteria	 Individual no longer has goal to be competitively employed. Individual requests discharge from TORS. Individual requests discharge from TORS. TORS goals in the Individualized Recovery Plan (IRP) have been substantially met; or Individual is unemployed and no longer receiving supported employment services; or If after 180 days of steady employment, individual has participated with natural supports and service providers in a planned transition from TORS to extended supports by the individual's behavioral health providers (e.g., Case Management; Peer Supports, etc.) and/or natural supports and has demonstrated the ability to continue successful employment without TORS.
Service Exclusions	 No service exclusions. If Supported Employment, ACT, PSR-Individual, Peer Support – Individual, CST, Non-Intensive Outpatient services, or other behavioral health and/or vocational rehabilitation services are provided simultaneously the individual's record must show evidence of integrated service coordination and effort to avoid duplication of services. Note that service integration may not be documented as a TORS billable unit.
Clinical Exclusions	Individuals with the following conditions are excluded from admission unless there is clearly documented evidence of a psychiatric condition co-occurring with one of the following diagnoses: Developmental Disabilities, Autism, and Neurocognitive Disorder.
Staffing Requirements	 10RS staff who do not hold licensure or certification as specified herein must comply with training requirements for paraprofessionals as outlined in Section II of this manual. TORS staff who do not have at least 1 year of delivering evidence-based supported employment services, must complete a minimum of 7.5 hours documented hours of training on evidence-based supported employment (IPS) within first 90 days. The program must be under the direct programmatic supervision of a LPC, LCSW, LMFT, Physician, Psychologist or CPRP, or staff who can demonstrate activity toward attainment of certification (e.g., current enrollment in CPRP courses/training, etc.). Specific to this programmatic supervision consists of the day-to-day oversight of the program as it operates and is demonstrated by monthly supervision sessions and documentation by the Supervisor. This individual must have at least 3 years of documentation by the Supervisor.

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5. Practitioners delivering this service are expected to maintain knowledge/skills regarding current research trends in best/evidence-based practices in recovery and, at a minimum, must maintain at least 5 hours of continuing education in the area of mental health recovery/year.	 Qualified DBHDD providers of adult mental health Individual Placement and Support (IPS) Supported Employment (SE) are required to be TORS providers. TORS providers must provide documentation that the creation of the TORS goals/objectives/interventions involved input from and collaboration with the individual. With permission from the individual, provider will document involvement and collaboration with his/her chosen supporters, including the individual's supported employment, behavioral health and vocational rehabilitation service providers and is based upon knowledge gained from the assessments and service plans of these respective providers, as well as the TORS provider's own assessment process. As indicated in the IRP, TORS goals and objectives should be based upon and reflect knowledge gained from the comprehensive assessment, as well as collaboration with the individual's BH, supported employment, vocational rehabilitation, etc. involved in the TORS goals/objectives/interventions in the IRP, the individual's wishes and coordination (or no coordination) should be included in assessments and progress notes. The TORS component of the overall IRP must state what the individual, as well as the individual's business and goals are achieved. Development of TORS goals in the IRP must include documented assessment of: a. Emotional triggers and behaviors related to behavioral health issues that may interfere with employment and ongoing engagement in meaningful and satisfying competitive employment. 	skills, resources, and supports that can be used to facilitate his/her achievement of employment goals. manage the symptoms, conditions and consequences associated with his/her mental illness that interfere yment goals. the individual but should not exceed the maximum of 8 units per day.	 The programmatic goals of this service must be clearly articulated by the provider, based on best practices for psychiatric rehabilitation as applied to the pursuit of and long-term engagement in meaningful and satisfying competitive employment. The organization must have a TORS Organization Plan that clearly articulates the programmatic goals of this service and addresses: a. How the core principles and values of the Psychiatric Rehabilitation Association are utilized to support vocational goals (http://uspra.ipower.com/Board/Governing_Documents/USPRA_CORE_PRINCIPLES2009.pdf); b. The models and types of psychiatric interventions that will be utilized to support individuals in attainment of vocational goals. 	How programmatic oversight or guidance by a CPRP will be provided; Protocols to ensure coordination and avoid duplication of services that are provided by the supported employment specialist or other behavioral health and/or vocational rehabilitation providers; and When and how TORS will be provided in conjunction with evidence-based (IPS-25) supported employment services and delivered in a manner that supports and is congruent with fidelity to this model (https://ipsworks.org/). It is should receive TORS from their current or most recent Supported Employment Provider. It is should receive and be closely coordinated with the goals, plans and activities of supported employment services and integrated into the Individual y Plan (IRP).	 Providers are expected to deliver TORS 100% of the time in the individual's work site or a community setting according to the individual's preferences for preferred location of service delivery. TORS must be available during daytime, evening and weekend hours to accommodate the needs of the individual served. 	 Provider is required to complete a progress note for every TORS contact with the individual. When provided in conjunction with supported employment and/or other behavioral health or vocational rehabilitation services, coordination of services should be evident in documentation as applicable. Documentation will reflect coordinated service integration as a "no charge". See #2 in Service Exclusions. All applicable Medicaid, ASO and DBHDD reporting requirements must be met.
	ø			vice		
	Required			Clinical/Service Operations	Service Accessibility	Documentation Requirements

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Temporary	Femporary Observation Services		
Transaction Code	Code Detail	Code Mod Mod Mod Mod Mod	Mod Rate
Crisis Intervention Mental Health Services	Temporary Observation Services	S9485	
Unit Value	1 Encounter (Admission)	MH Criteria TBD. SUD Criteria: Available to those known or of having ASAM III.7 level of care or lower	MH Criteria TBD. SUD Criteria: Available to those known or suspected of having ASAM III.7 level of care or lower
Service Definition	Temporary observation is a facility-based program that provides a physically secure and medically safe environment during which an individual in crisis is further assessed, stabilized and referred to the next appropriate level of care (generally within 24 hours). Interventions delivered during temporary observation may include any appropriate outpatient service including but not limited to: 1. Psychiatric Treatment, 2. Nursing Assessment, 3. Medication Administration, 4. Crisis Intervention, 5. Psychosocial Rehabilitation-Individual, 6. Case Management, 7. Peer Support-Individual 7. Peer Support-Individual Individuals will receive frequent observation, monitoring of objective signs and symptoms of withdrawal, symptom management, discharge and follow-up planning and referral.	t provides a physically secure and medically safe environment during which an individual in crisis is further ate level of care (generally within 24 hours). Interventions delivered during temporary observation may include ar to: ig of objective signs and symptoms of withdrawal, symptom management, discharge and follow-up planning and	observation may include any
Admission Criteria	Adult with a psychiatric condition or substance use disorder that has demonstrated via clinical assessment a degree of instability or disability that needs to be monitored, evaluated, and further assessed to determine the most appropriate level of care. This may include either discharge to community-based services or referral for admission to a higher level of care as needed; Individuals appropriate for temporary observation have demonstrated one or more of the following: 1. Further evaluation is indicated in order to clarify previously incomplete information prior to disposition; 2. Further stabilization is indicated prior to disposition; 3. There is evidence of an imminent or current psychiatric emergency without clear indication for admission to inpatient or crisis stabilization so that an alternative treatment in a psychiatric inpatient facility or crisis stabilization unit may be initiated; 3. There are indications that the symptoms are likely to respond to medication, structured environment, or brief withdrawal management resulting in stabilization so that an alternative treatment in a psychiatric inpatient facility or crisis stabilization unit. 5. Observation and continued care are necessary while awaiting transfer or referral to a higher level of care; and 7. There is evidence of a substance withdrawal related crisis, or intoxication, presenting as risk of harm without clear indication for admission to psychiatric inpatient facility or crisis stabilization unit.	ical assessment a degree of instability or disability include either discharge to community-based serservation have demonstrated one or more of the fort of disposition; cation for admission to inpatient or crisis stabilizated environment, or brief withdrawal management that way be initiated; I higher level of care; and I higher level of care; and I as risk of harm without clear indication for admising a stabilization for admising the stabilization for admission for a stabilization for admission for a stabilization for a stab	y that needs to be monitored, vices or referral for the following: tion treatment; resulting in stabilization so sion to psychiatric inpatient

TORS cannot be billed for the function of job development; training on job-specific skills or duties; or for any contact with or services provided to an employer.

TORS cannot be billed for service integration.

DBHDD providers of adult mental health Individual Placement and Support (IPS) Supported Employment (SE) are required to deliver TORS for all Medicaid-eligible

persons.

Requirements

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Femporary	Temporary Observation Services	
Discharge	The individual is considered appropriate for discharge when it has been determined that one of the following is clinically appropriate and arrangements for transfer or aftercare have been completed: 1. A higher level of care, such as a crisis stabilization unit or psychiatric inpatient facility: or	
Сптепа	commonly,	Cas
Service Exclusions	An individual shall not receive Temporary Observation services while receiving Crisis Stabilization Unit (CSU) services.	se 1:
	1. The individual can be safely maintained and effectively treated at a less intensive level of care. 2. The primary problem is social, economic (i.e., housing, family conflict, etc.), or one of physical health without a concurrent major psychiatric episode meeting the criteria for this level of care.	16-cv-(
Clinical Exclusions	ufficient severity to require acute psychiatric inpatient, crisis stabilization unit, medical, or surgical care (unless being provided scribed in Item (e) in Admission Criteria section above while awaiting transfer to crisis stabilization unit or inpatient psychiatric facility). an alternative to incarceration and is NOT accompanied by a covered DSM diagnosis of mental illness or substance use disorder. nust occur in programs operating under 290-9-12, Narcotic Treatment Programs.	03088-EL
	1. Temporary Observation is operational 24 hours a day, 7 days a week, offering a brief stay (generally less than 24 hours) in a medically monitored, safe environment for individuals requiring additional assessment and care, using licensed professionals.	R
Required Components	on services must be associated with:	Docun
	orary Observation services may vary in numbers of observation chairs or beds. This will be specified in contracts; or services must include service delivery under a physician's order and supervision along with nursing services and medication administration.	nent 4
		448-73
Staffing Requirements	area, as necessary, but remains the responsible license for the Temporary Observation service; A Licensed Practical Nurse or a second Registered Nurse to provide coverage by a licensed professional [and other duties as assigned] when the primary RN floats to the Crisis Service Center area. If the RN floats more than 50% of time during the shift, a second RN should be added for coverage of that shift;	Filed 1
		.1/29/2
	Service accessibility is managed and monitored via the GCAL Live Crisis Board. Providers are required to actively monitor and update changes to individuals being referred in or out of Temporary Observation.	3 F
Clinical	maintain current and up-to-date information, providers: May select an individual from the GCAL Live Crisis Board, or from another referral source to accept in temporary observation. Once the Provider accepts the individual, they will assign the individual to a temporary observation status on the inventory status board (via bhlweb).	Page 32
Operations	c. Once an individual leaves Temporary Observation, triey freed to be removed from temporary observation status on the inventory board of unisheried to a CoO bed. 2. This program individua all physicians, are under the supportion of a heard elicible Development who provides direction and everying the program constraints.	28 of
	A physician or physician extender (APRN or PA) shall be on call 24-hours/day and shall make rounds seven days/week. The physician is not required to be on site 24-hours/day, however, the physician must respond to staff calls immediately, with delay not to exceed one hour. A physician extender may also be used in an on- call	627

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Temporary	Temporary Observation Services			
	role but must always have access to a. Physician/physician extender cb. On Call Physician/Physician E. 5. Medication must be administered by O.C.G.A.	role but must always have access to consult with a physician or psychiatrist. a. Physician/physician extender coverage may include use of telemedicine. b. On Call Physician/Physician Extender response time must be within 60 minutes of initial contact by Temporary Observation staff. Medication must be administered by licensed or credentialed* medical personnel under the supervision of a physician or registered nurse in accordance with O.C.G.A.	ervation staff. registered nurse in accordance with	Cas
Additional Medicaid Requirements	N/A			se 1:16
Service Accessibility	 Services must be available by required/qualified staff 24 h A physician or physician extender delivering Temporary O 	ired/qualified staff 24 hours a day, 7 days a week with on-call response coverage including psychiatric services. elivering Temporary Observation services may utilize telemedicine as a mode of service delivery.	uding psychiatric services. ce delivery.	-cv-03
	Providers must report all individuals: a. The provider shall submit prior are selecting the appropriate service b. The provider shall submit a single 2. Temporary Observation may bill indi	 Providers must report all individuals served no matter the funding source (state-funded, Medicaid funded, private pay, other third-party payer, etc.): a. The provider shall submit prior authorization requests for all individuals served through the Provider Connect portal or through the batch submits services through Crisis Service Type of Care. b. The provider shall submit a single encounter for each Temporary Observation episode of care (i.e. Admission) for all individuals served. 2. Temporary Observation may bill individual discrete services for non-CMO Medicaid recipients as well as uninsured individuals. There is a Crisis Service type of care 	er third-party payer, etc.): through the batch submission process by ndividuals served.	3088-ELR
	available for use by the Temporary Observation provider. 3. The individual services listed below may be billed up to the daily units within the temporary observation are as follows:	available for use by the Temporary Observation provider. The individual services listed below may be billed up to the daily maximum listed for services provided in the Temporary Observations program. Billable services and daily units within the temporary observation are as follows:	Observations program. Billable services and	Docume
	Service	· ·	Max Daily Units	ent
	Behavir	Behavioral Health Assessment & Service Plan Development	12	44
	Diagnos	Diagnostic Assessment	2	8-7
Billing &	Interact Indivi	Interactive Complexity (as a modifier to Psychiatric Treatment, Diagnostic Assessment, Individual Counseling, and Group Counseling)	4	'3
Requirements	Crisis Ir	Crisis Intervention	14	File
	Psychie	Psychiatric Treatment	2	ed 1
	Nursing	Nursing Assessment & Care	14	11/:
	Medical	Medication Administration	_	29/
	Psycho	Psychosocial Rehabilitation - Individual	8	23
	Addictiv	Addictive Disease Support Services	16	
	Individu	Individual Outpatient Services	1	Pa
	Family	Family Outpatient Services	4	ge
	Case M	Case Management	12	329
	Peer St	Peer Support- Individual	8	of
	4. Only an active intervention between	Only an active intervention between a Temporary Observation practitioner and a served individual shall be billed as one of the items in the chart above	of the items in the chart above.	627

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Temporary	O	Temporary Observation Services
	<u> </u>	1. Documentation during the period of temporary observation shall be the following:
		a. Physician/physician extender order for admission to Temporary Observation;
		b. Verbal orders are acceptable if properly documented, as outlined in the Provider Manual (Part II, Section 3)
		c. Initial Assessment resulting in working diagnoses / diagnostic impression [including co-occurring diagnoses] and statement of plan for the Temporary
		Observation stay.
		d. Brief Psychiatric History
		e. Brief Physical Screening
Documentation		f. Brief Nursing Assessment
Requirements		g. RN progress note at least Q shift [Q 12 hours max] to include status, course of treatment, response to treatment and significant events or findings
		h. Discharge Order from Physician/physician extender
		i. Discharge summary paragraph to include:
		i. Care provided and outcome of care
		ii. Discharge diagnosis
		iii. Disposition / follow-up plan
		iv. Condition at discharge
	2	2. All individual services for which claims/encounters are submitted must be documented in accordance with requirements as specified in the Provider Manual.

	d Rate	TBD	ort to Le to work																
	d Mod		suppc continu																
	Mod 3	_	ture and numity,																
	Mod 2	TBD	e struci ∋ir comr				seling)												
	Mod 1	TBD	d requir				p Coun												
	Code	TBD	Program an	lements:			ng, and Grou												
	Code Detail	TBD	This is a time-limited, multi-faceted treatment model for adults who are enrolled in a Certified Accountability Court Program and require structure and support to achieve and sustain recovery from behavioral health conditions. These services enable individuals served to maintain residence in their community, continue to work	and go to school, and be part of their family life. The service model is comprised of the following unique service elements:			nteractive Complexity (as a modifier to Psychiatric Treatment, Diagnostic Assessment, Individual Counseling, and Group Counseling)												
	Rate	TBD	nrolled in a services ena	mprised of th			gnostic Asse												
	Mod 4		o are e These s	el is co	=		ent, Dia												
	Mod 3		dults whitions.	ce mod	aopmer		Treatme												
ases	Mod 2	TBD	del for ac	he servi	an Deve		chiatric ·												
e Dise	Mod 1	TBD	ent moc oral hea	ly life. T	Wice P	બ લક્ષ	r to Psy												Poo
Addictive	Code	TBD	aceted treatm y from behavi	rt of their fami	essment & St - (may contra	ıt	(as a modifie		(E&M)		tion	port Services	ervices	ices	/ices	Planning	lal		nlaw & Welln
Treatment Court Services- Adult Addictive Dise	Code Detail	TBD	This is a time-limited, multi-faceted treatment mod achieve and sustain recovery from behavioral hea	nd go to school, and be pa	. benavloral nealth Assessment & Service Plan Development Development	Diagnostic Assessment	Interactive Complexity	. Crisis Intervention	. Psychiatric Treatment (E&M)	. Nursing Services	. Medication Administration	. Addictive Disease Support Services	0. Individual Outpatient Services	 Group Outpatient Services 	2. Family Outpatient Services	13. Community Transition Planning	4. Peer Support - Individual	5. Peer Support - Group	16 Paer Support Whole Health & Wellness
nt Co		F	a I	<u></u>	c	1 က	4	5.	9	7.	∞.	6	<u> </u>	<u>+</u>	-	``	7	Ť	7
Treatmer	Transaction Code	TBD							00.20	Sel vice	רפוווווווווו								

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Treatment Co	Treatment Court Services- Adult Addictive Diseases	ddictive Diseases	
	The program incorporates DBHDD) into the individus	The program incorporates information from a validated risk and needs assessment (Identified by the Council of Accountability Court Judges [CACJ] and the DBHDD) into the individual's treatment planning process and resulting IRP. If the program administers the risk and needs assessment, versus taking receipt of it	
	Assessment and/or Servic Program utilizes methods.	Assessment and/or Service Plan Development services. Program utilizes methods, materials, settings, and outside resources appropriate to the developmental and cognitive levels, capabilities, age, gender, and culture	Ca
			se 1
	 Program utilizes methods, disorder, including those v 	Program utilizes methods, matenals, approaches, activities, settings, and outside resources appropriate for, and targeted to individuals with a substance use disorder, including those with a co-occurring mental health condition and/or developmental disability.	L:16
	4. Program utilizes methods, materials, at birth criminogenic risk and need levels	Program utilizes methods, materials, approaches, activities, and outside resources appropriate for reducing recidivism rates among individuals with moderate to	S-CV-
	5. Program maintains require	Program maintains required staff certification and training standards for evidence-based curricula/practices and provides quality control/model fidelity measures	030
	and supervision practices. 6. The program must operate	and supervision practices. The program must operate at a site approved to bill DBHDD/Medicaid for services. However, limited individual or group activities may take place off- site in	88-
		natural community settings as is appropriate to each individual's recovery plan. Program must have in place appropriate accreditation and licenses for all	ELR
	7. The program's treatment!	The program's treatment level and service frequency are based on the individual's clinical need and risk/support need considerations. However, in all cases, the	
		program must offer a minimum of nine (9) hours per week of programming at the initial phase of an individual's treatment.	Do
	8. The program provides ind identified court staff as so	The program provides individual treatment compliance and status reports prior to court staffing meetings. Any sanctionable offense should be reported to missed appointments	CUI
	inappropriate behavior tov	inappropriate behavior toward staff or other participants, damage to property, non-compliance with provider policies).	mer
Required	 The program works collab https://www.gaaccollabali 	The program works collaboratively with the court to implement evidence-based practices identified by the Georgia Council of Accountability Court Judges (CACJ https://www.gaaccountability.courts.org/) and the National Association of Drug Court Professionals (NADCP: Recommended: Best Practice Standards Vol Land II	nt 44
	https://www.ndci.org/resor	https://www.ndci.org/resources/publications/standards/).	48-
	10. Provide comprehensive In	Provide comprehensive Individual Recovery Plans (IRP) for each enrolled individual, including utilizing applicable adult outpatient services, residential supports	73
	and nousing, employment support services, and link	and nousing, employment supports, trauma informed mental neatin and substance use disorder treatment, whole heatin planning and implementation, peer support services, and linkage to other related services required to assist individuals in maintaining the behavioral health recovery and avoiding additional criminal	F
		ustice involvement. Evidence based practices will guide the IRP and treatment process.	ile
	11. The program will impleme	The program will implement at least one evidence-based treatment practice/model(s), using a manualized curriculum, that has shown to be effective in working	d 1
	with the target population, such as: Cognitive Behavioral Interv	target population, sucn as: Cognitive Behavioral Intervention – Substance Abuse	1/2
		Cognitive Behavioral Treatment (CBT)	9/23
	c. Marrix Model d Moral Reconation Therapy	n Therany	3
		viewing	Pa
			age
	g. Thinking for a Change h. Trauma Recovery and	Thinking for a Change Trauma Recovery and Empowerment Model (TREM)	33
	[NOTE: Not all the serv.	[NOTE: Not all the services listed in the Service Definition section are aligned with these unique EBPs, and therefore, these EBPs may not be applicable to	2 o
		those particular services. The court and providers will discern any specific applicability via their joint MOU.]	f 62
	providers, recovery commu	Provider will develop written agreements, partities inps., and memoration of understanding (MOU) with Rey Justice, memoration and substance abuse treatment providers, recovery community advocates and support partners, consumer groups on an ongoing basis for cooperative wrap-around services and for developing	27
	sustainable activities.		

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1. An individua toward mee assessmen assessmen 2. Each individual by exploring in groups. 3. Each individual and individual of substanc of substanc of substanc of substanc of substanc and if the special contract of substance and it the special contract of substance	Staff should be appropriately certified and trained on evidence-based practices and curricula. Staff should be appropriately certified and trained on evidence-based practices and curricula. For Group therapy: Maximum face-to-face ratio cannot be more than 10 individuals to 1 direct service staff based on average group attendance. A physician and/or Registered Nurse or Licensed Practical Nurse with appropriate supervision must be available to the program either employment by the agency, through a contract with a licensed practitioner, or by written referral or affiliation agreement with another agency or agencies that offer such services.
ю. 4:	An individual may have a variable length of stay. The level of care and length of stay should be determined by individual's multiple assessments and progress toward meeting goals of the IRP. It is recommended that the individuals attend at a frequency appropriate to their level of need. Ongoing clinical and risk/need assessment should be conducted to determine step down in level of care. Each individual should participate in setting individualized goals for themselves and in assessing their own skills and resources related to recovery. Goals are set by exploring strengths and needs in the individual's living, learning, social, and working environments. Implementation of services may take place individually or in proper
	Each individual must be provided assistance in the development/acquisition of needed skills and resources necessary to achieve recovery and/or reduction in use of substances and maintenance of recovery. Court staffing meeting time may be billable via ADSS with or without the person being present if the following are considered: a. If the Court Staffing Meeting addresses multiple individuals being supported by the Treatment Court Service, the only time which can be billed is the
ach star Co	specific discussion and planning related to the individual being served; The service must comply with the expectations set forth in the unique ADSS service definition (Assistance to the person and other identified recovery partners in the facilitation and coordination of the Individual Recovery Plan (IRP), identification, with the person, of strengths which may aid him/her in achieving and maintaining recovery from addiction issues as well as barriers that impede the development of necessary skills, etc.). For instance, if this staffing event is being billed via ADSS and the individual served is not participating, the intervention and billing would comply with the Required Components section of the ADSS service which allow 50% of billable contact to be non-face-to-face.
1. Service are avanta and a service are avanta and a service as the use a service as the use a service as a s	Service are available during the day and evening hours. Demographic information collected shall include a preliminary determination of hearing status to determine referral to Deaf Services. To promote access, providers may use Telemedicine as a tool to provide direct interventions to individuals for whom English is not their first language. Examples of this include: a. the use of one-to-one service intervention via Telemedicine, connecting the individual to a practitioner who speaks the individual's language versus use of interpreters; and/or
	b. the use of an interpreter via Telemedicine to support the practitioner in delivering the identified service. Telemedicine may only be utilized when delivering this service to an individual for whom English is not their first language. The individual must consent to the use of this modality. This consent should be documented in the individual's record. The use of telemedicine should not be driven by the practitioner's/agency's convenience or preference.
Documentation 1. Every admit Requirements 2. Daily notes	Every admission and assessment must be documented. Daily notes must include time in/time out in order to justify units being utilized.

Treatment Court Services- Adult Addictive Diseases

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ting of			Rate	TBD					
n the repor urposes.			d Mod 4						
luded i			Mod 3						
be inc			Mod 2	TBD					
iust not tendand			Mod 1	TBD					
d breaks m			Code	TBD	TBD	TBD	TBD		
individual was actively engaged in services. Meals and breaks must not be included in the reporting of program must be documented showing the number of hours in attendance for billing purposes. ented.			Code Detail	TBD	Maximum Daily Units	Re-Authorization	Utilization Criteria		
vas actively oust be docum			Rate	TBD					
vidual v ram mu d.			Mod 4						
the indithe the the tendente the the the the the the the the the t	is. igram:		Mod N						
in which pating in st be doo	vice bas rvice/pro		Mod 2	TBD					
s. bill units al particip idual mu	e-for-ser er this se	Healt	Mod 1	TBD					
ument and ad. ed. ed. ed. et. ed. et. et. et. et. et. et. et. et. et. et	sed on a fe illable unde sens ssts	t Menta	Code	TBD					
Provider shall only document and bill units in which the individuals of service delivered. Daily attendance of each individual participating in the programmer services contacts with an individual must be documented.	This service is reimbursed on a fee-for-service basis. The following are not billable under this service/program: a. Urine drug screens b. Travel time c. TB skin/RPR tests	rt Services- Adult Mental Health	Code Detail						

Treatment	Freatment Court Services- Adult Mental Health	t Menta	Healt	٦										
Transaction Code	Code Detail	Code	Mod 1	Mod Mod Mod 2 3 4	Mod 3	Mod 4	Rate	Code Detail	Code	Mod 1	Mod Mod Mod Mod 1 2 3 4	Mod 3	Mod 4	Rate
TBD	TBD	TBD	TBD	TBD			TBD	TBD	TBD TBD TBD	TBD	TBD			TBD
Unit Value	TBD							Maximum Daily Units	TBD					
Initial Authorization	TBD							Re-Authorization	TBD					
Authorization Period	TBD							Utilization Criteria	TBD					

Progress notes must include written daily documentation of groups, important occurrences; level of functioning; acquisition of skills necessary for recovery; progress on goals identified in the IRP, progress toward recovery, substance use, reduction and/or abstinence; use of drug screening results by staff; and

Treatment Court Services- Adult Addictive Diseases

evaluation of service effectiveness.

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Requirements Reporting Billing &

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Treatment	Treatment Court Services- Adult Mental Health	
	This is a time-limited, multi-faceted treatment model for adults who are enrolled in a Certified Accountability Court Program and require structure and support to achieve and sustain recovery from behavioral health conditions. These services enable individuals served to maintain residence in their community, continue to work and go to	bility Court Program and require structure and support to achieve aintain residence in their community, continue to work and go to
	school, and be part of their family life. The service model is comprised of the following unique service elements: 1. Behavioral Health Assessment & Service Plan Development	lements:
	2. Psychological Testing- (may contract out)	
	3. Diagnostic Assessment	
		al Counseling, and Group Counseling)
	5. Crisis Intervention	
	6. Psychiatric Treatment (E&M)	
Service	ice 7. Nursing Services	
Definition	ω.	
	9. Case Management	
	10. Individual Outpatient Services	
	11. Group Outpatient Services	
	12. Family Outpatient Services	
	13. Community Transition Planning	
	15. Peer Support - Group	
	17. Psychosocial Rehabilitation - Individual	
	An individual is referred by an Accountability Court and meets the following:	
	1. The individual is assessed as having a DSM psychiatric diagnosis that has caused significant functional impairment. Individual may also present with a co-	nctional impairment. Individual may also present with a co-
	occurring substance use disorder (SUD) or developmental disability; and	
	2. The individual's level of risk and support needs are assessed using a risk assessment tool supported by the Council of Accountability Court Judges (CACJ), and	orted by the Council of Accountability Court Judges (CACJ), and
Admission		and program treatment services; and
Criteria	က	ability Court program and treatment services; and
	4. The individual signs appropriate confidentiality waivers to allow communication of otherwise HIPAA-protected treatment information between the Accountability	AA-protected treatment information between the Accountability
	_	
	5. The individual is able to function in a community environment even with impairments in social, medical, family, or work functioning; and	ledical, family, or work functioning; and
	 b. I ne individual is sufficiently motivated to participate in treatment planning and recovery work. 	
	1. The individual's condition continues to meet the admission criteria; and	
	-2.	etworks and litestyle changes, increasing educational, vocational,
Continuing Stay Criteria	social and interpersonal skins, intering court program requirements, and establishing a communication a recovery program, but overall goals have not yet been met: and	ient to a recovery program,, but overan goals nave not yet been
Otay Office Ia	က်	ry reauthorization timeframe; and

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Ireatment	I reatment Court Services- Adult Mental Health
Discharge Criteria	 An adequate continuing care or discharge plan is established, linkages are in place, and one or more of the following: Goals of the IRP have been substantially met; or Clinical staff determines that the individual no longer needs this LOC; or Individual has completed or been discharged from the court program. Individuals discharged from the court program may continue with DBHDD community behavioral health services through a DBHDD-approved provider. Individuals discharged from the court program may continue with DBHDD community behavioral health services through a DBHDD-approved provider.
Service Exclusions	When offered with services with higher intensity, documentation must indicate efforts to minimize duplication of services and effectively transition the individuals to the appropriate services. This combination of services is subject to review of the ASO.
Clinical Exclusions	Individuals who do not meet the eligibility requirements per service category for each allowable service listed above for which participation is sought.
	 The program incorporates information from a validated risk and needs assessment (Identified by the Council of Accountability Court Judges [CACJ] and the DBHDD) into the individual's treatment planning process and resulting IRP. If the program administers the risk and needs assessment, versus taking receipt of it from a referring Accountability Court, it will be conducted by appropriately trained and credentialed staff. This may be provided through the Behavioral Health Assessment and/or Service Plan Development services.
	2. Program utilizes methods, materials, settings, and outside resources appropriate to the developmental and cognitive levels, capabilities, age, gender, and culture of participants.
	3. Program utilizes methods, materials, approaches, activities, settings, and outside resources appropriate for, and targeted to individuals with a serious mental illness, including those with a co-occurring substance use disorder and/or developmental disability.
	4. Program utilizes methods, materials, approaches, activities, and outside resources appropriate for reducing recidivism rates among individuals with moderate to high criminogenic risk and need levels.
	5. Program maintains required staff certification and training standards for evidence-based curricula/practices and provides quality control/model fidelity measures
	and supervision practices. 6. The program must operate at a site approved to bill DBHDD/Medicaid for services. However, limited individual or group activities may take place off- site in natural community settings as is appropriate to each individual's recovery plan. Program must have in place appropriate accreditation and licenses for all
Required Components	established service sites. 7. The program's treatment level and service frequency are based on the individual's clinical need and risk/support needs considerations. However, in all cases, the
	program must oner a minimum of 9 nours per week of programming at the initial phase of an individual streatment. 8. The program provides individual treatment compliance and status reports as needed prior to and during court staffing/judicial review meetings. Any sanctionable offense should be reported to identified court staff as soon as possible, or at least within 24 hours of the incident (sanctionable offenses include but are not limited
	to missed appointments, inappropriate behavior toward staff or other participants, damage to property, non-compliance with provider policies). 9. The program works collaboratively with the court to implement evidence-based practices identified by the Georgia Council of Accountability Court Judges (CACJ; http://www.gaaccountabilitycourts.ord) and the National Association of Drug Court Professionals (NADCP: Recommended: Best Practice Standards Vol. Land II
	https://www.ndci.org/resources/publications/standards/) 10. Provide comprehensive Individual Recovery Plans (IRP) for each enrolled individual, including utilizing applicable adult outpatient services, residential supports
	and housing, employment supports, trauma informed mental health and substance abuse treatment, whole health planning and implementation, peer support services, and linkage to other related services required to assist individuals in maintaining the behavioral health recovery and avoiding additional criminal justice
	olve pro
	a. Cognitive Behavioral Intervention – Substance Abuse b. Cognitive Behavioral Treatment (CBT)

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Treatmen	t Cou	Freatment Court Services- Adult Mental Health	_
		c. Matrix Model d. Moral Recognition Therapy e. Motivational Interviewing f. Seeking Safety g. Thinking for a Change	
	TON]	 Irauma Recovery and Empowerment Model (TREM) NOTE: Not all the services listed in the Service Definition section are aligned with these unique EBPs, and therefore, these EBPs may not be applicable to those particular services. The court and providers will discern any specific applicability via their joint MOUJ. 	
	12.	Provider will develop written agreements, partnerships, and memoranda of understanding (MOU) with key justice, mental health and substance abuse treatment providers, recovery community advocates and support partners, consumer groups on an ongoing basis for the purpose of cooperative wrap around services and for developing sustainable activities.	CV-03000
	-, 2	Staffing patterns must adhere to the requirements for each allowable service listed above. Provider shall employ the following staff exclusively dedicated to the Treatment Court - MH service: a. One FTE Treatment Coordinator who:	
		i. Is a licensed clinician; and ii. Provides all case management/care coordination for participants; and	
		iii. Attends courvistalings)judiciar reviews/planting sessions, and iv. Carries a case load size for any of the unbundled services iv. Carries a case load of all Treatment Court - MH participants in need of services (not to exceed the caseload size for any of the unbundled services named above in this service guideline): and	umen
Staffing		v. Conducts Behavioral Health Assessments for participants entering services. b. One FTE Certified Peer Specialist (with credentials as a Forensic Peer Mentor) who:	
Requirements		i. Has a certification as Peer Specialist-MH or AD; and ii. Is a graduate of Forensic Peer Mentor Training (or completes training within 6 mos. of hire); and	
		iii. Provides mentoring and linkage to community resources for participants; and	
			licu
	رب د.	vi. Carries a case load of all Treatment Court – MH participants in need of services. Staff should be appropriately certified and trained on evidence-based practices and curricula.	T T I I
	4. 4	For Group therapy: Maximum face-to-face ratio cannot be more than 10 individuals to 1 direct service staff based on average group attendance.	2312
	o.	A physicial align). Negistered hurse of Licensed Practica Nuise will appropriate supervision must be available to the program entire by employment by the agency of agencies that offer such services.	
	- -	An individual may have a variable length of stay. The level of care and length of stay should be determined by individual's multiple assessments and progress toward meeting goals of the IRP. It is recommended that the individuals attend at a frequency appropriate to their level of need. Ongoing clinical and risk/need	ray
Clinical	5.	Each individual should participate in setting individualized goals for themselves and in assessing their own skills and resources related to recovery. Goals are set	5 33 1
Operations		by exploining suchigus and needs in the marking and miners, and working changing in prementation of services may take place marking in groups.	UI
	რ	Each individual must be provided assistance in the development/acquisition of needed skills and resources necessary to achieve recovery and/or reduction in use	02
	4	of substances and maintenance of recovery. Court staffing meeting time may be billable as a collateral contact via Case Management with or without the person being present if the following are considered:	

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Women's Treatment and Recovery Support (WTRS): OutpatientOutpatientRateCode DetailCode DetailModRateCode Intensive Outpatient Unit ValueAAAAAAAAA See TOC Grid in Part I of this Manual for Services Billing detail. Utilization Criteria TBD	WTRS Outpatient Services will provide comprehensive gender specific treatment for addictions. These services will encompass ASAM Level 1 Outpatient services and ASAM Level 2.1 Intensive Outpatient Services. ASAM Level 2 outpatient Services. ASAM Level 2.1 is an intensive outpatient set of services that maybe provided in regularly scheduled sessions and follow a defined set of policies and procedures. ASAM Level 2.1 is an intensive outpatient set of services that maybe offered during the day, before or after work, in the evening or on weekends. Such programs provide essential support and treatment services while allowing the individual to apply his/her newly acquired skills in "real world "environments. The WTRS Outpatient Program assumes an average length of stay in outpatient treatment of 4 to 12 months or based on individual clinical need.	 Individual must: Have a substance use disorder; and Meet criteria for the DBHDD eligibility (Part I of this manual). Meet criteria for the DBHDD eligibility (Part I of this manual). These contracted slots are for any woman with no other means to pay for services (Corrections, DFCS, court referred, etc.). Admissions and Interim Services Policy for Pregnant Consumers: Federal regulations gives priority admissions to certain populations in the following order: Admissions and Interim Services Policy for Pregnant Consumers: Federal regulations gives priority admissions to certain populations in the following order:	 The individual's condition continues to meet the admission criteria; Documentation reflects continuing progress of the individual's recovery plan within this level of care; There is a reasonable expectation that the individual can achieve the goals in the necessary time frame; and In the event the length of stay needs to be extended, additional documentation is required to be submitted to the DBHDD Women's Treatment Coordinator. All services are individualized and clinical discretion is to be used when evaluating levels of care. The maximum length of stay is twelve (12) months. 	 A discharge/transition plan is completed, linkages are in place, and one or more of the following: Goals of the IRP have been substantially met; or If a consumer is involved with DFCS or another referring agency, a discharge staffing should be completed in collaboration with both WTRS and other referring organizations before discharge. To discharge an individual before clinically appropriate, a clinical staffing and a discharge summary must be completed, and the following information must be documented. Transfer to a higher level of service is warranted if the individual requires services not available at this level. 	Services cannot be offered with SA Intensive Outpatient Program, Psychosocial Rehabilitation, WTRS residential treatment, and AD Intensive service. 1. If an individual is actively suicidal or homicidal with a plan and intent. 2. Women should have no cognitive and/ or intellectual impairments which will prevent them from participating in and benefiting from the recommended level of care. 3. Withdrawal Management and impairments needs must be met prior to admission to the program (alternative provider and/ or community resources should be used to serve women with acute treatment needs).
Women' Transaction Code Intensive Outpatient Unit Value	Service Definition	Admission Criteria	Continuing Stay Criteria	Discharge Criteria	Service Exclusions Clinical Exclusions

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Women's Treatment and Recovery Support (WTRS): Outpatient Services

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	L	
		b. Level 4 practitioner with co-occurring disorders experience or higher staff as defined in the DBHDD Provider Manual.
		c. Non-clinical staff and Level 5 practitioners must be under the supervision of an LCSW, LPC, LMFT, MAC, CAADC, GCADC-II/-III, or CAC-II.
	4	WTRS Provider must have at least one program director to oversee residential and outpatient.
	5.	Each WTRS program must have a distinct separation in staff.
	9	The provider must provide assurance that all program staff will have appropriate background checks and credential verifications.
	1.	The program must be under clinical supervision of an LCSW, LPC, LMFT, MAC, CAADC, GCADC-II/-III, or CAC-II, who is onsite during normal operating hours.
	2.	All clinical services must be provided by the appropriate practitioner based on the DBHDD practitioner's guide.
	က်	The program shall conduct random drug screening and use the results of these tests for marking the individual's progress toward goals and for service planning.
	4	Addiction treatment/recovery services and programming must demonstrate a primary focus on Group Counseling that consists of Cognitive Behavioral groups (which
		rearrange patterns of thinking and action that lead to addiction). Group training, such as psychoeducational groups (which teach about substance use disorder and
		skills development groups, which hone the skills necessary to break free of addictions) may also be offered in combination with group counseling but must not serve
- Coicil		as the only group component. At least fifty percent (50%) of groups provided on a weekly based on the ASAM Level of Care must be counseling.
Operations	5.	Limited individual or group activities may take place off-site in natural community setting as is appropriate to each individual's IRP. (NO Services are to take place
	(at the individual s place of residence unless it is outleadily.
	o	Recovery Support meetings may not be counted towards nours for any treatment sessions it the session goes beyond the basic introduction to the Recovery Support experience
	7	Outpers Outperson. Hours of oneration should be accommodating for individuals who work (i.e. evening/weekend hours)
	. 00	WTRS services may operate in the same building as other services: however, there must be a distinct separation between services. Iiving space and staff
	5 6	Adequate space equipment furnishings supplies and other resources must be provided in order to effectively provide services and so that the program
	5	and the clean and in conditional repair.
	10	The Department's Evidence Based Practices and curriculums are to be utilized for the target area of treatment. Practitioners providing these services are
	2	
	7	The program must have a WTRS Services Organizational Plan Addressing the following:
		a. The philosophical model of the program and the expected outcomes for program participants (i.e., harm reduction, abstinence, beginning of or maintaining
		b. The schedule of activities and hours of operations.
		c. Staffing patterns for the program.
		g. How services for individuals with co-occurring disorders will be flexible and will include services and activities addressing both mental health and addictions.
		integrated services that are co-occurring enhanced as reflected in Guiding Principles Regarding Co-Occurring Mental Health and Addictive Diseases Disorders,
		04-109.
		i. How services will be coordinated with addiction services including assuring or arranging tor appropriate referrals and transitions (Including
	5	(ransportation).
	7	stall trailing and development is required to be addressed by the provider as evidenced by the community standards. HFR a. All WTRS treatment om staff are required to participate in staff development and ongoing training as required by the community standards. HFR
		b. As a part of this already mandated staff development and training, WTRS staff should have at least thirty (30) hours of addiction specific training
		annually, in accordance with HFR regulations.

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All employees including house parents should complete the SAMHSA's Introduction to Women and Substance Use Disorders On-Line Course within 90 days of employment. To enroll in the Introduction to Women and Substance Use Disorders On-line course go to: https://healtheknowledge.org/ addition modalities and treatment skills. All non-licensed and or non-certified staff that provide services must complete at least 6 hours of gender specific training, annually. All employees including house parents should complete the SAMHSA's Introduction to Women and Substance Use Disorders on-line course go to: https://healtheknowledge.org/ . Training can be provided via e-learning or face to face. Each treatment provider is required to train new program staff on the following: i. Understanding the WTRS program requirements; ii. Understanding ASO expectations and requirements; iii. Understanding ASM levels of care; and v. Understanding ASAM levels of care; and v. Understanding current DECS policies related to the WTRS program.	15 世 岩 の 日 % 5 苺 6 *	The formust of the second most be documented. WTRS providers are required to provide a complete biopsychosocial assessment. Level of Care will be determined according to the American Society of Addiction Medicine (ASAM) for assessing the severity and intensity of services the content of the ANSA. The ASAM justification form must be included in consumer's chart. The ANSA. The ASAM justification form must be included in consumer assessment within 30 days of admissions. Assessment must be placed in consumer's medical record.	t and Recovery Support (WTRS): Residential Treatment Code H0043 H0043

Licensed and certified staff is required to have at least six (6) hours out of the thirty (30) hours in the area of gender-specific women's addiction

Women's Treatment and Recovery Support (WTRS): Outpatient Services

modalities and treatment skills.

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Women's I	reatment and Recovery Support (WIRS): Resid	(S): Kesidential Treatment	ent				
Transaction	Code Detail	Code	Mod 1	Mod 1 Mod 2 Mod 3 Mod 4 Rate	Mod 3	Mod 4	Rate
Code							
Supported	loitachian d	10042					
Housing	רקטומפוווים	2400					

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ChildCare. ASAM Level 3.1 programs offer at least 10 hours per week of low-intensity treatment focusing on improving the individual's readiness to change. Services may include individual, group, and family therapy; medication management and medication education, mental health evaluation and treatment; vocational rehabilitation and job placement; and either introductory or remedial life skills workshops. Level 3.1 is a structured recovery residence environment; staffed 24 hours a day, which provides sufficient stability to prevent or minimize relapse or continued use. Interpersonal and group living skills generally are promoted through use of community or house meetings of residents and staff. Level 3.5 programs are designed to serve individuals who, because of specific functional limitations, need safe and stable living environments in order to develop and/ or demonstrate sufficent recovery skills so that they do not immediately relapse or continue to use in an imminently dangerous manner upon transfer to a less intensive level of care. This level of care assist individuals who addiction is currently so out of control that they need a 24 hour supportive treatment environment to initate or continue a recovery process that has failed to progress. 3.5 programs provides no less than 25 hours of treatment is provided for dependent children ages 13 and younger. The provider, may but is not required, to provide an onsite and safe living environment for children 14-17. Therapeutic Child Care provided to ensure the children of the women receive the necessary therapeutic provinces and interventions skills. The provider will comprehensively address wraparound services available on-site or off site, for dependent children developed and on-site or provided within walking developed and provider will comprehensively address wraparound services available on-site or off site, or dependent children developed and provider will comprehensively address wraparound services available on-site or off site, and address than a service or	 1. Individuals must have a substance use disorder, meet the DBHDD eligibility (Part I of this manual), and meets criteria for one of the following: a. TANF and or Child Protective Service Criteria: i. Current TANF Recipients- Individuals with active TANF cash assistance cases. iii. Families at Risk- Individuals whose TANF assistance was terminated within the previous twelve months due to employment. iii. Families at Risk- Individuals whose TANF along with other required documents must be in individual's chart. OR b. Non-TANF Criteria: Individuals determined to be Non-TANF and does not meet the above criteria but do meet the DBHDD eligibility definition may be served in a WTRS program. An individual is determined to be Non-TANF by the following: 	 i. A woman pregnant for the first time. ii. A woman pregnant for the first time. iii. A woman has lost parental custody of her children (i.e. is not working on reunification). iii. A woman who is not associated with DFCS (TANF or Child Protective Service, meets DBHDD eligibility definition and would benefit from gender specific treatment). iv. A woman with no dependent children. OR c. SSBG and/or state funded slots 	 A woman with dependent children who meet the DBHDD Eligibility definition. Each time an individual is discharged they must meet the admission criteria and follow admission procedure if re-admittance is needed. Federal regulations give priority admissions to certain populations in the following order: Pregnant injecting drug users, other pregnant drug users, and all other users. All addictions providers are required to adhere to the priority admission policy (including pregnant women that are actively taking opiate substitute). In the event a woman is unable to continue her medication regimen the provider must make appropriate referrals and contact the state office within 48 hours. 	1. The individual's condition continues to meet the admission criteria. 2. Documentation reflects continuing progress of the individual's recovery plan within this level of care.

Admission Criteria

Women's Treatment and Recovery Support Residential Program will provide comprehensive gender specific treatment for addictions. These services will encompass ASAM level 3.1 Clinically Managed Low -Intensity Residential Services and 3.5 Clinically Managed High-Intensity Residential Services level of care and Therapeutic

Utilization Criteria

Women's Treatment and Recovery Support (WTRS): Residential Treatment

Unit Value

Service Definition

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m rd}$ Quarter Provider Manual for Community Behavioral Health Providers (January 1, 2023)

Stay Criteria

Continuing

l s.uewo	Women's Treatment and Kecovery Support (WTKS): Residential Treatment 3. There is a reasonable expectation that the individual can achieve the goals in the necessary time frame. 4. In the event the length of stay needs to be extended, additional documentation is required to be submitted to the DBHDD Women's Treatment Coordinator. All senices are individualized and clinical discretion is to be used when evaluating levels of care. The maximum length of stay is six (6) months.	
Discharge Criteria	 Goals of the IRP have been substantially met; and Discharge/ transition plan is completed, and linkages are in place; OR Transfer to a higher level of service is warranted if the individual requires services not available at this level. To discharge an individual before clinically appropriate, a clinical staffing and a discharge summary must be completed with documentation of the clinical justification for the higher level of care. If an individual is involved with DFCS, a discharge staffing should be completed in collaboration with WTRS providers and other referring organization(s) before discharge. 	Case 1:16-c
Service Exclusions	Services cannot be offered with SA Intensive Outpatient Program, WTRS Outpatient Treatment Service, Psychosocial Rehabilitation, or other residential treatment service. 1. If an individual is actively suicidal or homicidal with a plan and intent.	v-0308
Clinical Exclusions		88-ELR
	Services must be licensed by DCH/HFR under the Rule Each individual should participate in setting individualiz Services may take place individually or in groups. Each individual must be oriented into the program and IRP reviews must be completed every 30 days and staf WTRS Treatment Review Form is recommended. Use of ASAM is required to determine level of care duri judgment must be used. All WTRS providers must be providing all services incl. All WTRS providers must offer the following groups: Ad Thinking, Anger Management, Co-Occurring Disorders, The commended of the control of th	Document 448-73 Filed
Required Components	 9. The recommended curriculums for the above groups are: a. The MATRIX with the women supplement; b. Helping Women Recover; c. A Woman's Way Through the 12 Steps; d. Beyond Trauma; e. TREM; 	d 11/29/23
	 Seeking Safety; A New Direction Criminal and Addictive Thinking; Matrix Family Component; Matrix Family Component. Providers are required to maintain a waiting list. All individuals placed on waiting list should be contacted at least twice a month. If the provider has a priority admission on the waiting list. Interim services must be offered and documentation is required to on the waiting list. If the provider has insufficient capacity to provide services to any such pregnant woman, the provider is required to refer the pregnant woman to the DBHDD Women's Treatment Coordinator. The provider is required to make interim services available within 48 hours if pregnant woman cannot be admitted because of lack of capacity. 	Page 344 of 627

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Women's Tr	reat	Women's Treatment and Recovery Support (WTRS): Re	oort (WTRS): Residential Treatment	eatment		
	13.	The program is required to offered interim services at a. Counseling and education about HIV and TB, t	ed interim services at a minimum the following: about HIV and TB, the risks of needle-sharing	ogram is required to offered interim services at a minimum the following: Counseling and education about HIV and TB, the risks of needle-sharing, the risks of transmission to sexual partners and infants, and steps that can be	and steps that can be	
		taken to ensure that HIV a	taken to ensure that HIV and TB transmission does not occur; Referral for HIV and TB treatment services, if necessary; and			(
	4	5	nen on the effects of alcohol and other red ASAM content hours:	Counseling pregnant women on the effects of alcohol and other drugs use on the fetus and referrals for prenatal care for pregnant women. art below shows the required ASAM content hours:	l women.	Case
	:	A	ASAM Level of Care	Hours Per Week		2 1:
		<u>ר</u> נ	-evel 3.5	25 hours		16
		<u> </u>	-evel 3.1	10 hours		i-cv
	1.	1. Program Coordinator Qualifications:				/-0 3
		a. At least two (2) years of do	ocumented work experience in a Gende	At least two (2) years of documented work experience in a Gender Specific and/or Addiction Treatment Program.	3	3 0 8
			occurring disorders experience derined Jemonstrate actual staff capabilities in u	Lever 4 or nigher with co-occuring disorders experience defined in the DBHDD Provider Mandar. This person's knowledge must go beyond basic understanding and must demonstrate actual staff capabilities in using knowledge for individuals with co-occuring disorders. Staff person must	beyond basic erson must	8-E
		demonstrate a minimum	of 5 hours per year of training in co-occ	a minimum of 5 hours per year of training in co-occurring treatment. Programs must have documentation that there is at least one (1) Level	at least one (1) Level	ELF
		4 staff (excluding Parapro	ofessional, Supervisee/Trainee and Ce	4 staff (excluding Paraprofessional, Supervisee/Trainee and Certified Alcohol and Drug Counselor-Trainee) that is co-occurring capable. A GCADC-Lor CAC-Lworking towards obtaining a GCADC-II or CAC-II within two years can work in this position. The provider is required to keep	oable.	?
		≧	id anticipated the test date.			Do
	2	Program Manager or Lead Counselor qualifications:	selor qualifications:			cu
Staffing			cumented work experience in a Gende	At least one (1) year of documented work experience in a Gender Specific and /or Addiction Treatment Program.	: : :	me
Requirements		 b. Level 4 practitioners or a CAC-I with co-occurring providers 	CAC-I with co-occurring disorders expe	ng disorders experience or higher staff as defined in the Provider Manual tor Community Behavioral Health	ınıty Behavioral Health	ent
	က်	Programmatic Staff Qualifications:				44
		a. All WTRS practitioners with	h no documented experience should be	All WTRS practitioners with no documented experience should be orientated on the biological and psychosocial dimensions of substance use disorders	tance use disorders	8-7
		and trained in evidence-k	based models and best practices. This	and trained in evidence-based models and best practices. This orientation should also include "Introduction to Women and Substance Use Disorders"	ance Use Disorders"	73
			On-line course. This must be completed within the first 90 days of employment.	of employment.	: :	F
		b. Level 4 practitioner with co	o-occurring disorders experience or high	Level 4 practitioner with co-occurring disorders experience or higher staff as defined in the Provider Manual for Community Behavioral Health Providers.	oral Health Providers.	=ile
	4	The WTRS Provider must have at	C. Non-clinical stail and Level 3 practitioners into the under the supervision of an orisine LCS. The WTRS Provider must have at least one program director to oversee residential and outpatient.	residential and outpatient.	- , O O O - .	ed 1
	. ك	Each WTRS program must have distinct separation in staff.	listinct separation in staff.			.1/2
	۰.	The provider must provide assurar	االا الانكارا المالية program staff will have appr التقالية التقالية ا	The provider must provide assurance that all program staff will have appropriate background checks and credential verifications.		29/2
	. ~	All clinical services must be provided by the appropriate	al supervision of an ECSW, LFC, LINE I ed by the appropriate practitioner base	The programmes be under chilical supervision of an ECSVV, EPC, Eivir 1, MAC, CAADC, GCADC, III-III, or CAC-II, who is offsite during normal operating nous. All clinical services must be provided by the appropriate practitioner based on the DBHDD practitioner's quide.	ilai operatiilig Hours.	23
	რ	The program shall conduct random drug screening and	n drug screening and use the results of	use the results of these tests for marking the individual's progress toward goals and for service planning	for service planning.	F
	4.	Addiction treatment services and p	programming must demonstrate a prima	Addiction treatment services and programming must demonstrate a primary focus on Group Counseling that consists of Cognitive Behavioral groups (which	al groups (which	Pa
Clinical		rearrange patterns of thinking and	action that lead to addiction), group tra	rearrange patterns of thinking and action that lead to addiction), group tra ining, such as psychoeducational groups which teach about substance use disorders and	ance use disorders and	ge 3
Operations		as the only group component. At le	east fifty percent (50%) of groups provid	as the only group component. At least fifty percent (50%) of groups provided on a weekly basis on the ASAM Level of Care must be group counseling.	ounseling.	345
	5.	Limited individual or group activitie	is may take place off-site in natural com	Limited individual or group activities may take place off-site in natural community setting as is appropriate to each individual's IRP. (NO Services are to take place	rices are to take place	of
	9	at the individual splace or residence unless it is outlead, Recovery support meetings (such as AA, NA, etc.) may no	se diffess it is outleadily. as AA, NA, etc.) may not be counted to	at the individuals place of residence unless it is outlead by. Recovery support meetings (such as AA, NA, etc.) may not be counted towards hours for any treatment sessions.		627
	7.	WTRS services may operate in the	same building as other services; howe	WTRS services may operate in the same building as other services; however, there must be a distinct separation between services, staff, and living space.	d living space.	

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Adequate space, equipment, furnishings, supplies and other resources must be provided in order to effectively provide services and so that the program

Treatment

(WTRS): Residential

Women's Treatment and Recovery Support

environment is clean and in good repair

9.

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Women's 7	듩	
	 Every admission and assessment must be documented. Every admission and assessment must be documented. Progress/Group notes must be written daily and signed by the staff that performed the service. Daily attendance of each individual participating in the program must be documented by evidence of a group sign in roster. Clinicians are to sign and date each note with only the correct approved DBHDD credentials based on the practitioners table included within this manual. The individual that provides the service must complete the note. 	Case 1:10
	 All WTRS providers are required to complete a biopsychosocial assessment. All WTRS providers are required to complete a biopsychosocial assessment. The Level of Care will be determined according to the American Society of Addiction Medicine (ASAM) 3rd edition for assessing severity and intensity of services and the ANSA. The ASAM justification form must be included in the individual's medical record. The provider must complete the WTRS vocational assessment within 30 days of admissions. Assessment must be placed in the individual's medical record. TANE and Child Protective Service individuals must be referred by DECS. 	6-cv-03088-
	12. The following information must be maintained in the individual's chart, including all appropriate signatures: a. Substance Use Disorder Assessment Result Form: Substance Use Disorder Assessment Results form must be completed and submitted back to DFCS within 2 weeks from the completion of the assessment (Fmail or Fax documenting submission to DFCS)	ELR
	 b. WTRS Referral Form completed by DFCS: i. Release of Information Form completed by DFCS. ii. Email or fax documenting transmission from DFCS. iii. Email or fax documenting submission to DFCS from DFCS. 	Docume
	13. All WTRS providers must submit the WTRS Compliance Form to DFCS within 72 hours for the following: a. If individual fails to show for appointments for three consecutive days; b. All other major non-compliant issues; and c. Email or Fax documenting submission to DFCS.	ent 448-73
Billing & Reporting Requirements	Span billing may occur for this service, meaning the start and end date are not the same on a given service claim line; however, spans cannot cross months (e.g. start date and end date must be within the same month).	B File
Women's Transaction	Women's Treatment and Recovery Services: Transitional Housing Transaction Code Detail Code Detail Code Detail Code Detail Code Detail Mod Nod Nod Nod Nod Nod Nod Nod Nod Nod N	d 11/29/23

	ModModModModRate1234	Ready for Work Transitional Housing provide a safe, stable, drug free residence and utilities (power and water) for no more than 6 months to any woman or woman with	a child that has successfully completed all recommended treatment/recovery services. The environment should be gender specific and can include dependent children	programs; thus, a successful	A woman or woman with a child(ren) that has successfully completed all recommended levels of treatment unless approval from Women's Program Coordinator. A woman that has provided evidence of needing a place of residence. A woman that has provided evidence being able to live in a community environment without the assistance of direct care staff.
	Code	o more than 6	ender specific	or outpatient p	ess approval from the staff
	Code Detail	utilities (power and water) for no	. The environment should be g	om Ready for Work residential mis necessary.	A woman or woman with a child(ren) that has successfully completed all recommended levels of treatment unless approval from A woman that has provided evidence of needing a place of residence. A woman that has provided evidence being able to live in a community environment without the assistance of direct care staff.
5	Rate	ence and ı	y services	service fו Service fi 12 progra	all recomn y environm
Jousin	Mod Mod Mod Rate	ree resid	ıt/recoveı	p down ir SAM leve	mpleted ssidence. ommunit
H leuoi	Mod 3	le, drug f	treatmer	be a ste	ssfully co lace of re ive in a o
ransit	Mod 2	afe, stab	mended	sing is to ent, or le	as succeseding a particular point and a particular part
L.Ses.	Code Mod	vide a s	III recom	nal Hous , outpati	that here of neese of being
Servic	Code	ising pro	ıpleted a	Transitio sidential	child(rer evidenc evidenc
Women's Treatment and Recovery Services: Transitional Housing	Code Detail	Ready for Work Transitional Hou	 child that has successfully com 	between birth and 18 years old. Transitional Housing is to be a step down in service from Ready for Work residential or outpatient programs; thus, a successful completion of Ready for Work residential, outpatient, or least an ASAM level 2 program is necessary.	1. A woman or woman with a child(ren) that has successfully completed 2. A woman that has provided evidence of needing a place of residence. 3. A woman that has provided evidence being able to live in a community.
Women's Tre	Transaction Code		Service	Definition b	Admission Criteria

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Continuing Stay Criteria	 The individual's condition continues to meet the admission criteria. Documentation reflects continuing progress of the individual's IRP. There is a reasonable expectation that the individual can achieve the goals in the necessary time frame. In the event the length of stay needs to be extended additional documentation is required to be submitted to the state DBHDD Women's Treatment Coordinator. All services are individualized and clinical discretion is to be used. The maximum length of stay is six (6) months. 	Case :
Discharge Criteria	 A discharge / transition plan completed, linkages are in place, and one or more of the following: Goals of the IRP have been substantially met; or If an individual is involved with DFCS, a discharge staffing should be completed in collaboration with WTRS providers and other referring organizations before discharge. Documented reason for early appropriate, a clinical staffing must be completed and provide the following information:	1:16-cv-03088-ELF
Service Exclusions	Services cannot be offered with Psychosocial Rehabilitation, WTRS residential or other residential treatment service.	R [
Clinical Exclusions	 If an individual is actively suicidal or homicidal with a plan and intent. Women should have no cognitive and/or intellectual impairments which will prevent them from participating in and benefiting from the recommended level of care. Withdrawal Management and impairments needs must be met prior to admission to the program (alternative provider and/ or community resources should be used to serve women with acute treatment needs). Women must be medically stable in order to reside in an independent living condition and participate in treatment. 	Document 4
	 Provider will conduct a residence check twice a month to ensure cleanliness and safety. The housing must be in the community away from the primary residential treatment facilities. If children are residing with their mother, provider must child proof the home. 	48-73
Required Components	 The home must provide a barring from and dining area, a kitchen and a bedroom for all residents. The home must provide a living room and dining area, a kitchen and a bedroom for all residents. This is a step-down program. Women living in transitional housing must be individuals to attend treatment/support services, this may include public transportation fare, staffing transporting individuals using agency vehicles and/or providing gas for individual's automobile. Provider should continue to work with the individual's referral source to ensure consistency of care. 	Filed 11/29
Staffing Requirements	No staffing requirements for this level of care. Follow outpatient staffing requirements when providing aftercare treatment and support services.	/23
Clinical Operations	 Transitional Housing Services must provide a schedule for aftercare programming and to ensure stability and consistency for individuals. Individual should be in Level 1 outpatient/aftercare. If she does not meet the criteria or the agency does not have a WTRS outpatient program, the individual should have an SA Outpatient. Transitional Housing Services may be in the same apartment complex (that is not owned by the provider) as residential services; however, the living quarters must be distinctly different. Preferably (not required) apartments are away from residential services to assist with acclimation back into the community. Food and shopping must be completed by individuals; providers should not charge or collect money/EBT cards. Medications and medical needs should be the responsibility of the individual. The providers should not hold or dispense medications to individuals in transitional housing. 	Page 348 of 627

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 Women's Treatment and Recovery Services: Transitional Housing 6. Transitional Housing must have an organizational plan addressing the following: a. Schedule of Activities and Hours; b. Policies and Procedures; c. House Rules for Consumers; and d. Emergency Procedures. 7. Each individual should participate in setting individual goals for themselves and in assessing their own skills and resources related to sobriety. 8. Aftercare services must be provided to all participants in transitional housing should have access to outpatient services. (Please see WTRS Outpatient Admission) 9. The women living in Transitional Housing should have access to outpatient services. (Please see WTRS Outpatient Admission) 	. Affercare i a. b. c. d. d. f.	← ci	 Bi-weekly unit inspection must be documented for transitional housing. Results of Drug Screen must be documented. Results of Drug Screen must be documented. If individual is a Child Protective Services or TANF referral from DFCS, a Monthly WTRS Compliance Form is required (Email or Fax documenting submission to DFCS) from DFCS). If individual is a Child Protective Services or TANF referral from DFCS, the WTRS providers must submit the WTRS Compliance Form to DFCS within 72 hours (Email or Fax documenting submission to DFCS) for the following scenarios: a. If individual fails to show for treatment appointments for three consecutive days; and b. All other major non-compliance issues. 	Span billing may occur for this service, meaning the start and end date are not the same on a given service claim line; however, spans cannot cross months (e.g. start date and end date must be within the same month).
Women			Documentation Requirements	Billing & Reporting Requirements

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SECTION IV
TABLE A: PRACTITIONER DETAIL

Please see the next page for Practitioner Detail

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ursing Assm\& Care nursing assm\evaluafon RN Services

LPN Services

individual psychotherapy face to face with medical evaluation and L management services

sychiatric Treatment

Structured Residential Services

Ambulatory Detoxification

vice Plan Development

Support Whole Health

Peer Support-Parent

services fherapeutic, propylactic, or diagnostic injection

comprehensive Medicatior

ensive Case Management

dividual Counseling

oup Counseling

edication Administration

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m rd}$ Quarter Provider Manual for Community Behavioral Health Providers (January 1, 2023)

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Practitioners Table □ey/Superscript Explanation

Light green shading denotes services for which telemedicine may be billed only if English is not
the person's primary language. Dar green shading denotes services/practitioner types for which
telemedicine may be billed for any person (regardless of the person's primary language). Always
reference the actual service guideline of interest for further guidance/clarification.

- With at least a bachelor's degree in one of the helping professions such as social work, community counseling, counseling, psychology, or criminology, functioning within the scope of the practice acts of the state.
- With at least a bachelor's degree in one of the helping professions such as social work, community counseling, counseling, psychology, or criminology.
- Addictions counselors may only perform these functions related to treatment of substance use disorders, including when there is a known or suspected co-occurring disorder.
- 4 With high school diploma/equivalent.
- □ Under the documented supervision (organizational charts, supervisory notation, etc.) of one of the licensed/credentialed professionals who may provide this service.
- ☐ Modifiers indicate services for which it is required to submit and document "U" levels an "x" denotes services for which a "U" modifier is not required to submit an encounter.
- With a Master's/Bachelor's degree in behavioral or social science that is primarily psychological in nature under the supervision of a licensed practitioner.
- 8 With high school diploma/equivalent under supervision of one of the licensed/credentialed professionals who may provide this service.
- 9 Working only within a Community Living Arrangement.
- 10 In conjunction with a psychologist.
- 11 Excludes LCSW/LPC/LMFT Supervisee/Trainees.
- 12 Under supervision of a Physician, Psychologist, LCSW, LPC, LMFT, RN, APRN, PA, LMSW, APC, or LAMFT.
- 13 LPNs who are "paraprofessionals" having completed the STR.
- 14 Please see the Community Requirements for full titles of practitioners.
- 1□ Under supervision of a Physician, Psychologist, LCSW, LPC, LMFT, RN, APRN, PA, CAC-II, GCADC-II or -III, MAC, or CAADC.
- 1□ Supervisee/Trainers are not able to bill Crisis Psychotherapy codes 90839.
- 17 While RNs may bill for the Individual modality of the service, they may not bill for the Group modality.
- 18 Information gathering only See service guideline
- 19 Other professional services are billed unbundled as referenced in the service guideline.
- 20 Telemedicine is allowed only for the "Individual" modality of this service.

See Approved BH Practitioners Table for more detail on the practitioners listed in this table.

TABLE B: Physicians¹, Physician's Assistants and APRNs² may order any service. Please use the chart below to determine other appropriately licensed practitioner(s) authorized to recommend/order specific services.

Orderi	ng Practitioner Guidelines	Licensed Psychologist	LPC, LMFT, LCSW
	Addictive Disease Support Services	Х	X
	Behavioral Health Assessment & Service Plan Development	X	Х
	Behavioral Health Clinical Consult		
	Case Management (adults only)	X	Χ
sec	Community Support – Individual (youth only)	X	Χ
Non-Intensive Outpatient Services	Community Transition Planning	X	Χ
Ser	Crisis Intervention	X	Χ
ä	Diagnostic Assessment	X	Χ
atie	Family Outpatient Services (Counseling & Training)	X	Χ
utb	Group Outpatient Services (Counseling & Training)	X	Χ
0 0	Individual Counseling	X	Χ
siv	Medication Administration		
ten	Nursing A/H Services		
툿	Peer Support- Individual ³	X	Χ
٥̈	Peer Support Whole Health & Wellness (adults only) ³	X	Χ
	Peer Support – Group - Parent & Youth (youth only) ³	X	Χ
	Psychiatric Treatment		
	Psychological Testing	X	X
	Psychosocial Rehabilitation-Individual (adults only)	Χ	Χ
	Community Inpatient / Detoxification		
<u>₹</u>	Crisis Stabilization Program		
C&A Specialty	Intensive Customized Care Coordination	X	Х
ed c	Intensive Family Intervention	X	X
₹	Peer Support- Parent & Youth- Individual & Group ³	X	X
రొ	Structured Residential Supports	X	X
	SA Intensive Outpatient: C&A	, , , , , , , , , , , , , , , , , , ,	
	·		
	Ambulatory Detoxification		
	Assertive Community Treatment		
	Community Inpatient / Detoxification	V	V
	Community Support Team Crisis Stabilization Unit Services	X	X
		V	V
	Housing Supplements	X	X
<u>~</u>	Intensive Case Management	X	X
Adult Specialty	Opioid Maintenance Treatment		
bed	Peer Support (includes MH/AD Programs & Individual 3)	X	X
S =	Peer Support Whole Health and Wellness ³	X	X
np\	Psychosocial Rehabilitation Program	X	X
⋖	Residential SA Detoxification		
	Respite	X	X
	Residential Supports	X	X
	SA Intensive Outpatient: Adult		
	Supported Employment/Task Oriented Rehabilitation	X	Х
	Temporary Observation	quirements (i.e. they function	

¹ Resident physicians are allowed to order services in accordance with their residency supervision requirements (i.e. they function as a physician for ordering allowance purposes).

² APRNs include Clinical Nurse Specialists (CNS) and Nurse Practitioners (NP)
3 Peer Support- Individual, PSWHW, Parent Peer Support, and Youth Peer Support are in both the Non-Intensive Outpatient and Specialty groups.

SECTION V Service Code Modifier Descriptions

Certain services in the Service Guidelines contain specific modifiers. The following is a list of the modifiers included herein and their specific description:

Modifier	Description and Associated Rules
D1	Utility Deposits*
ES	Equipment/Supplies*
ET	Emergency Services
FG	Food/Grocery*
FS	Financial Services*
GT	Via Interactive audio/video telecommunication systems
HA	Child/Adolescent Program
HE	Mental Health Program
HF	Substance Abuse Program
HH	Integrated mental health/substance abuse program
HK	Specialized Mental Health Programs for High-Risk Populations
HQ	Group Setting
HR	Family/Couple with client present
HS	Family/Couple without client present
HT	Multidisciplinary team
HW	Funded by state mental health agency
H1	Household Furnishings*
H2	Household Goods and Supplies*
H9	Court-ordered
M1	Moving Expenses
RR	Rental
R1	Residential Level 1*
R2	Residential Level 2*
R3	Residential Level 3*
SE	State and/or federally funded programs/services
S1	Security Deposits*
TB	Transitional Bed*
TF	Intermediate Level of Care
TG	Complex Level of Care
TN	Rural
TS	Follow-up Service
UC	State-defined code, Participant Self-Directed
UJ	Services provided at night
UK	Collateral Contact
U1	Practitioner Level 1
U2	Practitioner Level 2
U3	Practitioner Level 3
U4	Practitioner Level 4
U5	Practitioner Level 5
U6	In-Clinic

U7	Out-of-Clinic*
Modifier	Description and Associated Rules
ZC	From CSU*
ZH	From State Hospital*
ZJ	From Jail / YDC / RYDC*
ZO	From Other Institutional Setting*
ZP	From PRTF*

^{*} Represents a state-defined modifier which will is not represented in standard CPT or HCPCS coding.



PART II

Community Service Requirements for Behavioral Health Providers

Provider Manual for Community Behavioral Health Providers

Fiscal Year 2023

COMMUNITY SERVICE REQUIREMENTS FOR ALL PROVIDERS SECTION I: POLICIES AND PROCEDURES

1. Guiding Principles

- A. Integration into community: Inclusion and community integration for both the provider and the individuals served is supported and evident.
 - i. Individuals have responsibilities in the community such as employment, volunteer activities, church and civic membership and participation, school attendance, and other age-appropriate activities
 - ii. The provider has community partnerships that demonstrate input and involvement by:
 - 1. Advocates:
 - 2. The person served;
 - 3. Families; and
 - 4. Business and community representatives.
 - iii. The provider makes known its role, functions and capacities to the community including other organizations as appropriate to its array of services, supports, and treatment as a basis for:
 - 1. Joint planning efforts;
 - 2. Continuity in cooperative service delivery, including the educational system;
 - 3. Provider networking;
 - 4. Referrals; and
 - 5. Sub-contracts.
 - iv. AD providers who receive SAPTBG funds shall publicize the availability of services and the preference extended to pregnant women through its outreach programs, ongoing public service announcements (radio/television), regular advertisements in local/regional print media, posters placed in targeted areas, and frequent notification of availability of such treatment distributed to the network of community based organizations, health care providers, and social service agencies. SAPTBG
 - v. Providers receiving SAPTBG grant dollars for treatment/support services for intravenous drug users must encourage the participation of such individuals through a strategy that reasonably can be expected to be an effective but, at a minimum, shall include:
 - 1. Selecting, training and supervising outreach workers;
 - 2. Contacting, communicating and following-up with individuals with substance use disorders, their associates, and neighborhood residents, within the constraints of Federal and State confidentiality requirements, including 42 C.F.R. Pt 2;
 - Promoting awareness among individuals with substance use disorders about the relationship between intravenous drug use and communicable diseases such as HIV, and recommending steps to prevent disease transmission; and
 - 4. Encouraging entry into treatment. SAPTBG
 - vi. For agencies who provide any combination of Community Behavioral Health, Psychiatric Residential Treatment Facility (PRTF), and/or Room/Board/Watchful Oversight (RBWO) services, the agency must ensure appropriate distinctions between these programs to include but not limited to physical, financial, administrative, and programmatic separation. Additional guidance may be found in the PRTF Provider Manual.
- B. Access to individualized services.
 - Access to appropriate services, supports, and treatment is available regardless of, Age; Race, National Origin, Ethnicity; Gender; Religion; Social status; Physical disability; Mental disability; Gender identity; Sexual orientation.
 - ii. There are no barriers in accessing the services, supports, and treatment offered by the provider, including but not limited to:
 - 1. Geographic;
 - 2. Architectural:
 - 3. Communication:

- Language access is provided to individuals with limited English proficiency or who are sensory impaired;
- b. All applicable DBHDD policies regarding Limited English Proficiency and Sensory Impairment are followed;
- c. Individuals who identify as deaf, deaf-blind, or hard of hearing or who are suspected of having a hearing loss are referred to the Office of Deaf Services to receive a Communication Assessment to determine level of communication need for service access as in Provider Procedures for Referral and Reporting of Individuals with Hearing Loss, 15-111.
- 4. Attitudinal;
- Procedural:
- 6. Organizational scheduling or availability; and
- 7. Services provided in school settings are allowable up to 3 hours/week as a general rule, and the clinical record shall include documentation of partnership with the school.
 - a. When an exception to provide more than 3 hours/week is recommended by the ordering practitioner, it should be documented in the IRP and in a supporting administrative note to include evidence of clinical/access need (challenges with in-home or clinic access, CANS scores, recent discharge from inpatient hospitalization, PRTF, CSU, etc.).
 - b. The DBHDD wants youth to be successful in attaining their educational goals and, so, if a course of service is recommended in the IRP to occur during the youth's educational school day (not before or after school), an administrative note in the record should indicate a plan for minimizing school disruption and why the course of intervention occurs during school hours instead of before/after school, in the home, in clinic, or in other community settings. This documentation is not necessary when there is not a plan for regular school-day services and an unplanned intervention must occur to stabilize a behavioral health situation.
 - c. Youth receiving this service must never be taken out of the classroom for the convenience of the service provider.
 - d. DBHDD services and supports should not supplant but should complement what schools provide for support of a child based on the IEP.
- 8. Providers that receive SAPTBG funds will treat the family as a unit and admit both women and their children into treatment/support services, if appropriate. Programs must provide, or arrange for the provision of, the following services to pregnant women and women with dependent children, including women who are attempting to regain custody of their children:
 - a. Primary medical care for women, including referral for prenatal care and, while the women are receiving services, childcare;
 - b. Primary pediatric care, including immunization, for their children;
 - c. Gender specific substance abuse treatment and other therapeutic interventions for women, which may address issues of relationships, sexual and physical abuse, parenting, and childcare;
 - d. Therapeutic interventions for children in custody of women in treatment which may address developmental needs, sexual and physical abuse and neglect; and
 - e. Sufficient case management and transportation to ensure access to services. SAPTBG
- 9. Providers that receive SAPTBG funds provide individuals using intravenous drugs access to a treatment program not later than:
 - a. Fourteen (14) days after making the request for admission to a program; or
 - b. One hundred and twenty days after the date of such request, if:
 - i. No such program has the capacity to admit the individual on the date of such request, and
 - ii. Interim services, including referral for prenatal care, are made available to the individual not later than 48 hours after such request. SAPTEG
- 10. Wellness of individuals is facilitated through:
 - a. Advocacy;
 - b. Individual service/treatment practices;
 - c. Education;
 - d. Sensitivity to issues affecting wellness including but not limited to:
 - i. Gender:

- ii. Culture; and
- iii. Age.
- e. Incorporation of wellness goals within the individual plan.
- 11. Sensitivity to individual's differences and preferences is evident.
- 12. Practices and activities that reduce stigma are implemented.
- 13. If services include provision in non-clinic settings, providers must have the ability to deliver services in various environments, such as homes, schools, homeless shelters, or street locations. Individuals/families may prefer to meet staff at community locations other than their homes or other conspicuous locations (e.g., their school, employer).
- 14. The organization must have policies that govern the provision of services in natural settings and can document that it respects youth and/or families' right to privacy and confidentiality.
- 15. Staff should be sensitive to and respectful of the individual's privacy/confidentiality rights and preferences to the greatest extent possible (e.g. if staff must meet with an individual during their school/work time, choosing inconspicuous times and locations to promote privacy), especially if staff drive a vehicle that is clearly marked as a state or agency vehicle, or if staff must identify themselves and their purpose to engage with the individual in a way that may potentially embarrass the individual or breech the individual's privacy/confidentiality.
- 16. Telemedicine may be used as a means to access individualized service when the Service Guideline allows this practice (See Part I, Section III). Telemedicine is the use of medical information exchanged from one secured site to another via electronic communications to improve a patient's health. Electronic communication means the use of interactive telecommunications equipment that includes, at a minimum, audio and video equipment permitting two-way, real time interactive communication between the patient, and the physician or practitioner at the distant site.
 - a. The telemedicine connection must ensure HIPAA compliance related to Privacy and Security (employing authentication, access controls and encryption to allow for patient/client confidentiality, integrity and availability of their data).
 - b. The following definitions apply:
 - i. Originating Site: Individuals being served via telemedicine may be located at home, schools, other community-based settings, or at more traditional sites.
 - ii. Distance Site: The site where the practitioner providing the professional service is located at the time the service is provided via a telecommunications system.
 - c. All individuals served via telemedicine (DBHDD state-funded and Medicaid FFS) must sign a consent form. For Medicaid-covered individuals, the Department of Community Health requires that: "The Telemedicine Member Consent Form for each individual is outlined in the Telemedicine Guidance Document and must be utilized." ¹ For individuals served using DBHDD state funds, providers may also use the DCH consent form (or create one containing the same basic information/components, as applicable).
 - d. To promote access, providers who are using Telemedicine as a tool to provide direct interventions to individuals for whom English is not their first language are exempt from:
 - i. The required percent of community-based services ratios defined in the Service Definitions herein: and
 - ii. The required minimum face-to-face expectations (allowing face-to-face to be via telemedicine).

¹ To access the Consent Form: https://www.mmis.georgia.gov/portal/; then click Provider Information > Provider Manuals > Telemedicine Guidance.

THE FOLLOWING CONTENT WILL REPLACE THE LANGUAGE IN ITEM #16 ABOVE WHEN THE NATIONAL COVID-19 PUBLIC HEALTH EMERGENCY (PHE) ENDS:

- 16. Telemedicine and telephonic interventions may be used as a means to deliver personcentered services, in accordance with the following:
 - a. Definitions:
 - i. "Telemedicine" is the use of medical information exchanged from one secured site to another, via electronic communications, to improve a patient's health. Electronic communication means the use of interactive telecommunications equipment that includes, at a minimum, audio and video equipment permitting two-way, real time interactive communication between the patient, and the physician or practitioner at the distant site.
 - 1. Originating Site: The site where individuals are being served via telemedicine (i.e. this may be at their homes, in schools, in other community-based settings, or at more traditional service sites).
 - 2. Distance Site: The site where the practitioner providing the professional service is located at the time the service is provided via a telecommunications system.
 - ii. "Telephonic" is the use of medical information exchanged between one individual and another, via an audio-only communication exchange made by telephone.
 - iii. "Face-to-Face" (FTF) language is found throughout the BH Provider Manual, and is herein redefined to mean either "in-person" or "via the use of telemedicine technology," based upon the provider's clinical judgment in accordance with the criteria set forth in item "g" below. However, "Face-to-Face" is never inclusive of telephonic intervention.
 - b. The telemedicine connection must ensure HIPAA compliance related to Privacy and Security (employing authentication, access controls and encryption to allow for patient/client confidentiality, integrity and availability of their data).
 - c. All individuals served via telemedicine (DBHDD state-funded and Medicaid FFS) must sign a consent form, a copy of which must be placed in each individual's health record. For Medicaid-covered individuals, the Department of Community Health requires that: "The Telemedicine Member Consent Form for each individual is outlined in the Telemedicine Guidance Document and must be utilized." For individuals served using DBHDD state funds, providers may either use the DCH consent form, or create one containing the same information/components, as applicable.
 - d. All individuals served via telephone (DBHDD state-funded and Medicaid FFS) must also sign a consent form, a copy of which must be placed in each individual's health record. Providers should either create a separate form containing the same applicable information/ components as is utilized in their telemedicine consent form, or may combine the consents into a single form so long as consent to each modality (telemedicine vs. telephonic) is clearly delineated.
 - e. Limits regarding telephonic service delivery may exist for certain services. Any such limits can be found in the Service Definition for the specific service in question (see Part I of this manual), and must be adhered to.
 - f. Telephonic service delivery must adhere to the 2022 released guidance from the U.S. Department of Health and Human Services, Office for Civil Rights¹.
 - g. The use of telemedicine or telephonic service delivery should never be driven by the practitioner's or agency's convenience or preference. Telemedicine and telephonic service delivery should only be deployed based on sound clinical judgement, and with documented consideration of the following:
 - The nature and complexity of the service, and of the particular service intervention(s) to be implemented;
 - ii. The individual's needs and preferences:

- iii. The individual's current clinical presentation and life circumstances (e.g. symptom type and acuity, risk of harm, a significantly stressful and recent life event, etc.);
- iv. The individual's access to, and comfort with technology;
- v. The individual's ability to have private and confidential conversations/interactions with the provider;
- vi. Safety of the individual's home environment or other environment where the individual is receiving services;
- vii. The potential for viable strategies to address any of the above, as well as any other barriers that may exist.
- viii. Frequent re-evaluations of telemedicine/telephonic service delivery in consideration of the above, and any other factors that may impact the feasibility of these service delivery modalities.
- To promote access, providers may use Telemedicine as a tool to provide direct interventions to individuals for whom English is not their first language. Examples of this include:
 - the use of one-to-one service intervention via Telemedicine, by connecting the individual to a practitioner who speaks the individual's language (i.e. rather than using an interpreter); and/or
 - the use of an interpreter via Telemedicine (i.e. as a third party) to support the practitioner in delivering the identified service to an individual.
- Provider agencies must have a written policy that addresses all of the above sub-items listed under item 16. Telemedicine and telephonic interventions. This policy must address implementation plans/protocols, including internal staff training, documentation in the individual's health record (including the expected frequency of re-evaluations regarding telemedicine/ telephonic modality appropriateness), self-evaluation measures, and internal record review procedures.
 - US Department of Health and Human Services, Office for Civil Rights. (June 13, 2022). Guidance on How the HIPAA Rules Permit Covered Health Care Providers and Health Plans to Use Remote Communication Technologies for Audio-Only Telehealth. https://ula.hhs.gov/hipaa/for-professionals/privacy/guidance/hipaa-audiotelehealth/inde □html
- 17. Interactions with individuals demonstrate respect, careful listening, and are positive and supportive.

2. **Required Business Practices and Policies**

- Program requirements, compliance, and structure:
 - Applicable statutory requirements, rules, regulations, licensing, accreditation, and contractual/agreement requirements are evident in organizational policies, procedures and practices. In the event that the above requirements and standards are more stringent than these requirements, providers shall defer to those requirements which are most stringent.
- Providers receiving MHBG funds must comply with Public Law 102-321, Section 1912 and applicable code sections at http://www.samhsa.gov/. MHBG Funds cannot be spent to:
 - i. Provide inpatient services;
 - ii. Make cash payments to intended recipients of health services;
 - To purchase or improve land; purchase or construct or permanently improve (other than minor remodeling) any building or other facility; or purchase major medical equipment;
 - To satisfy any requirement for expenditure of non-federal funds as a condition for the receipt of federal funds; and
 - To provide financial assistance to any entity other than a public or non-profit private entity.
- C. Providers receiving SATBG funds must comply with 45 CFR 96 Rules and Regulations at http://www.samhsa.gov/.

- The provider shall adhere to companion requirements as published by the Department of Community Health regarding behavioral health services and facilities:
- The provider shall adhere to supplementary requirements as published by the Administrative Services Organization:
 - 1. Organizations must update their contact information on the Georgia Collaborative ASO's website as required:
 - 2. For all services, a provider must request a Registration for an individual to whom services/supports will be provided.
 - 3. Authorization requests must be submitted for those services identified as requiring such authorization:
 - 4. Providers have 48 hours from initial contact to submit Registrations (exceptions being crisis and acute services):
 - 5. Providers have 48 hours from initial contact to submit the Authorization (exceptions being crisis and acute services).
 - 6. Claims are required to be submitted to the ASO within ninety (90) days from date of service delivery. For those providers who are approved Fee-for-Service providers, delivering named Fee-for-Service services, claims are reimbursed by the DBHDD through the ASO.
- The provider clearly describes available services, supports, and treatment.
- The provider has a description of the services that have been approved by DBHDD and DCH along with the supports, care and treatment provided which includes a description of:
 - i. The population served;
 - ii. How the provider plans to strategically address the needs of those served; and
 - Services available to potential and current individuals.
- The provider has internal structures that support good business practices.
 - There are clearly stated current policies and procedures for all aspects of the operation of the organization;
 - Policies and corresponding procedures direct the practice of the organization; and
 - Staff is trained in organization policies and procedures. iii.
 - There is a formal code of conduct for the organization to formally communicate moral behavioral standards for the organization's staff and guidelines for ethical decision making.
- The provider details the desired expectation of the services, supports, and treatment offered and the outcomes for each of these services.
 - The level and intensity of services, supports, and treatment offered is:
 - 1. Within the scope of the organization;
 - 2. According to benchmarked practices; and
 - 3. Timely as required by individual need.
- The provider has administrative and clinical structures that are clear and that support individual services.
 - Administrative and clinical structures promote unambiguous relationships and responsibilities.
 - The provider bills in accordance with payer policies, and when an individual has questions regarding billing/fees, the provider offers assistance to the individual in understanding the explanation of benefits and/or billing statement.
- The program description identifies staff to individual served ratios for each service offered:
 - Ratios reflect the needs of individuals served, implementation of behavioral procedures, best practice guidelines and safety considerations.
- Policies, procedures and practice describe processes for referral of the individual based on ongoing assessment of individual need:
 - Internally to different programs or staff; or

- ii. Externally to services, supports, and treatment not available within the organization including, but not limited to healthcare for:
 - 1. Routine assessment such as annual physical examinations;
 - Chronic medical issues (Specific to AD providers, if tuberculosis or HIV are identified medical issues, services such as diagnostic testing, counseling, etc. must be made available within the provider or through referrals to other appropriate entities [although these services are not required as a condition of receiving treatment services for substance abuse, and are undertaken voluntarily and with the informed consent of the individual SAPTBG);
 - 3. Ongoing psychiatric issues;
 - 4. Acute and emergent medical and/or psychiatric needs;
 - 5. Diagnostic testing such as psychological testing or labs; and
 - Dental services.
- J. In the event that the SAPTBG provider has insufficient capacity to serve any pregnant woman seeking AD treatment, the provider will refer the woman to the DBHDD. SAPTBG
- K. In the event that the SAPTBG provider has insufficient capacity to serve any individual using intravenous drugs who is seeking AD treatment, the provider shall establish a system for reporting unmet demand to the DBHDD.
 - i. The provider, upon reaching 90 percent of service capacity, must notify the DBHDD within seven days.
 - ii. A waiting list shall use a unique patient identifier for each individual using injected drugs who is seeking treatment, including those receiving interim services while awaiting admission to such treatment. The reporting system shall ensure that individuals who cannot be placed in comprehensive treatment within 14 days receive ongoing contact and appropriate interim services while awaiting admission. SAPTEG
- L. Quality Improvement and Risk Management: Quality Improvement Processes and Management of Risk to Individuals, Staff and Others is a Priority.
 - i. There is a well-defined quality improvement plan for assessing and improving organizational quality. The provider is able to demonstrate how:
 - 1. Issues are identified;
 - 2. Solutions are implemented;
 - 3. New or additional issues are identified and managed on an ongoing basis;
 - 4. Internal structures minimize risks for individuals and staff;
 - 5. Processes used for assessing and improving organizational quality are identified; and
 - 6. The quality improvement plan is reviewed/updated at a minimum annually and this review is documented.
 - ii. Indicators of performance are in place for assessing and improving organizational quality. The provider is able to demonstrate:
 - 1. The indicators of performance established for each issue:
 - a. The method of routine data collection;
 - b. The method of routine measurement:
 - c. The method of routine evaluation;
 - d. Target goals/expectations for each indicator; and
 - e. Outcome Measurements determined and reviewed for each indicator on a quarterly basis.
 - 2. Distribution of Quality Improvement findings on a quarterly basis to:
 - a. Individuals served or their representatives as indicated;
 - b. Organizational staff;
 - c. The governing body; and
 - d. Other stakeholders as determined by the governance authority.
 - 3. At least five percent (5%) of records of persons served are reviewed each quarter. Records of individuals who are "at risk" are included. Record reviews must be kept for a period of at least two years.
 - 4. Reviews include determinations that:

- a. The record is organized, complete, accurate, and timely;
- b. Whether services are based on assessment and need;
- c. That individuals have choices;
- d. Documentation of service delivery including individuals' responses to services and progress toward IRP goals;
- e. Documentation of health service delivery;
- Medication management and delivery, including the use of PRN /OTC medications; and their effectiveness; and
- g. That approaches implemented for persons with challenging behaviors are addressed as specified in the *Guidelines for Supporting Adults with Challenging Behaviors in Community Settings*. (www.dbhdd.georgia.gov).
- 5. Appropriate utilization of human resources is assessed, including but not limited to:
 - a. Competency;
 - b. Qualifications;
 - Numbers and type of staff, required based on the services, supports, treatment, and needs of persons served; and
 - d. Staff to individual ratios.
- 6. The provider has a governance or advisory board made up of citizens, local business providers, individuals and family members. The Board:
 - a. Meets at least semi-annually;
 - b. Reviews items such as but not limited to:
 - i. Policies:
 - ii. Risk management reports;
 - iii. Budgetary issues; and
 - iv. Provides objective guidance to the organization.
- 7. The provider's practice of cultural diversity competency is evident by:
 - Staff articulating an understanding of the social, cultural, religious and other needs and differences unique to the individual;
 - i. That such articulation, respect, and inclusion of cultural diversity will include Deaf Culture.
 - ii. Staff honoring these differences and preferences (such as worship or dietary preferences) in the daily services/treatment of the individual; and
 - iii. The inclusion of cultural competency in Quality Improvement processes.
- 8. There is a written budget which includes expenses and revenue that serves as a plan for managing resources. Utilization of fiscal resources is assessed in Quality Improvement processes and/or by the Board of Directors.
- 9. Areas of risk to persons served and to the provider are identified based on services, supports, or treatment offered including, but not limited to:
 - i. Incidents: There is evidence that incidents are reported to the Office of Incident Management as required by:
 - a. Reporting Deaths and Other Incidents in Community Services, 04-106; and
 - b. Investigating Deaths and Other Incidents in Community Services, 04-118.
 - ii. Accidents;
 - iii. Complaints;
 - iv. Grievances;
 - v. Individual rights violations including breaches of confidentiality;
 - vi. There is documented evidence that any restrictive interventions utilized must be reviewed by the provider's Rights Committee;
 - vii. Practices that limit freedom of choice or movement;
 - viii. Medication management; and
 - ix. Infection control preventive measures (specifically, AD providers address tuberculosis and HIV SAPTBG), to minimize risk of infectious disease transmission.

10. The provider participates in DBHDD consumer satisfaction and perception of care surveys for all identified populations. Providers are expected to make their facilities and individuals served accessible to teams who gather the survey responses (e.g., the *Georgia Mental Health Consumer Network*).

3. Consumer Rights

- A. Rights and Responsibilities
 - i. All individuals are informed about their rights and responsibilities:
 - 1. At the onset of services, supports, and treatment;
 - 2. At least annually during services;
 - 3. Through information that is readily available, well prepared and written/signed (e.g. American Sign Language) using language accessible and understandable to the individual; and
 - 4. Evidenced by the individual's or legal guardian signature on notification.
 - ii. The provider has policies and promotes practices that:
 - 1. Do not discriminate:
 - 2. Promote receiving equitable supports from the provider;
 - 3. Provide services, supports, and treatment in the least restrictive environment;
 - 4. Emphasize using least restrictive interventions;
 - 5. Incorporate Clients Rights or Patient's Rights Rules found at, www.dbhdd.ga.gov as applicable to the provider; and
 - 6. Delineates the rights and responsibilities of persons served.
 - iii. In policy and practice, the provider makes it clear that under no circumstances will the following occur:
 - 1. Threats (overt or implied);
 - 2. Corporal punishment:
 - 3. Fear-eliciting procedures;
 - 4. Abuse or neglect of any kind;
 - 5. Withholding nutrition or nutritional care;
 - 6. Withholding of any basic necessity such as clothing, shelter, rest or sleep; or
 - 7. Withholding services due to hearing status or communication fluency.
 - iv. For all community based programs, practices promulgated by DBHDD or the Rules and Regulations for Clients Rights, Chapter 290-4-9 are incorporated into the treatment of individuals served.
 - v. For all crisis stabilization units serving adults, children or youth, practices promulgated by DBHDD or the Rules and Regulations for Patients' Rights, Chapter 290-4-6 are incorporated into the treatment of adults, children and youth served in crisis stabilization units.
 - vi. For all programs serving individuals with substance use and abuse issues, in addition to practices promulgated by DBHDD or the Rules and Regulations for Clients Rights, Chapter 290-4-9, confidentiality procedures for substance abuse; individual records comply with 42 CFR, Part 2, Confidentiality of Alcohol and Drug Abuse Patient Records, Final Rule (June 9, 1987), or subsequent revisions thereof.

B. Grievances

i. Grievance, complaint and appeals of internal and external policies and processes are clearly written in language accessible to individuals served and are promulgated and consistent with all applicable DBHDD policies regarding *Complaints and Grievances* regarding community services. Notice of procedures is provided to individuals, staff and other interested parties, and providers maintain records of all complaints and grievances and the resolutions of same.

C. Safety Interventions

- i. Providers must work with each enrolled individual to develop, document, and implement, as needed, a crisis/safety plan.
- ii. Providers must have a process in place to provide after-hours accessibility and have the ability to respond, face-to-face as clinically indicated, to crisis and unsafe situations that occur with enrolled individuals in a timely manner per the contact/agreement with DBHDD. The Georgia Crisis and Access Line (GCAL) are not to be used as the safety plan or after hour's access for enrolled individuals. However, providers may utilize

- GCAL in order to gain access to higher levels of care (e.g., Crisis Stabilization Units, other inpatient services, etc.) or facilitate coordination with Georgia Emergency Management Agency services (i.e. 911).
- The organization must have established procedures/protocols for handling emergency and crisis situations that describe methods for supporting individuals/youth as they transition to and from psychiatric hospitalization.
- In policy, procedures, and practice, the provider makes it clear whether and under what circumstances the following restrictive interventions can be implemented based on the service(s) provided by the provider and licensure requirements. In all cases, federal and state laws and rules are followed and include but are not limited to the following:
 - 1. Use of adaptive supportive devices or medical protective devices;
 - May be used in any service, support, and treatment environment; and
 - b. Use is defined by a physician's order (order not to exceed six calendar months).
 - Written order to include rationale and instructions for the use of the device. C.
 - Authorized in the individual resiliency/recovery plan (IRP). d.
 - Are used for medical and/or protective reason (s) and not for behavior control.
 - Time out (used only in co-occurring DD or C&A services): 2.
 - Under no circumstance is egress restricted;
 - Time out periods must be brief, not to exceed 15 minutes: b.
 - Procedure for time-out utilization incorporated in behavior plan; and C.
 - d. Reason justification and implementation for time out utilization documented.
 - Personal restraint (also known as manual hold or manual restraint): The application of physical force. without the use of any device, for the purpose of restricting the free movement of a person's body:
 - May be used in all community settings except residential settings licensed as Personal Care Homes:
 - Circumstances of use must represent an emergency safety intervention of last resort affecting h. the safety of the individual or of others;
 - Brief handholding (less than 10 seconds) support for the purpose of providing safe crossing, C. safety or stabilization does not constitute a personal hold:
 - If permitted, personal restraint (ten seconds or more), shall not exceed five (5) minutes and this d. intervention is documented; and
 - For an individual who is deaf, deaf-blind, or hard of hearing who primarily communicates in sign language, the restraint must allow some movement of hands and fingers for communication access. Hearing assistive technology shall only be removed when it presents an immediate safety issue and shall be returned as soon as the safety issue is resolved.
 - 4. Physical restraint (also known as mechanical restraint): A device attached or adjacent to the individual's body that one cannot easily remove and that restricts freedom of movement or normal access to one's body or body parts.
 - Prohibited in community settings **except** in community programs designated as crisis stabilization units for adults, children or youth;
 - Circumstances of use in behavioral health, crisis stabilization units must represent an emergency safety intervention of last resort affecting the safety of the individual or of others:
 - For an individual who is deaf, deaf-blind, or hard of hearing who primarily communicates in sign language, the restraint must allow some movement of hands and fingers for communication access. Hearing assistive technology shall only be removed when it presents an immediate safety issue and shall be returned as soon as the safety issue is resolved.
 - 5. Seclusion: The involuntary confinement of an individual alone in a room or in any area of a room where the individual is prevented from leaving, regardless of the purpose of the confinement. The practice of "restrictive time-out" (RTO is seclusion and may not be utilized except in compliance with the requirement related to seclusion. The phrase "prevented from leaving" includes not only the use of a locked door, but also the use of physical or verbal control to prevent the individual from leaving.
 - Seclusion may be used in the community **only** in programs designated as crisis stabilization programs for adults, children or adolescents;
 - Circumstances of use in behavioral health crisis stabilization programs must represent an b. emergency safety intervention of last resort affecting the safety of the individual or of others; and

- Is not permitted in developmental disabilities services.
- 6. Chemical restraint may never be used under any circumstance. Chemical restraint is defined as a medication or drug that is:
 - Not a standard treatment for the individual's medical or psychiatric condition; a.
 - Used to control behavior: and b.
 - Used to restrict the individual's freedom of movement.
- Examples of chemical restraint are the following:
 - The use of over-the-counter medications such as Benadryl for the purpose of decreasing an individual's activity level during regular waking hours; and
 - The use of an antipsychotic medication for a person who is not psychotic but simply 'pacing' or mildly agitated.
- 8. PRN antipsychotic and mood stabilizer medications for behavior control are not permitted. See Part II, Section 1; Appendix 1 for list of medications.
- Confidentiality: The provider maintains a system of information management that protects individual information and that is secure, organized and confidential.
 - All individuals determine how their right to confidentiality will be addressed, including but not limited to:
 - 1. Who they wish to be informed about their services, supports, and treatment;
 - 2. Collateral information. When collateral information is gathered, information about the individual may not be shared with the person giving the collateral information unless the individual being served has given specific written consent.
 - The provider has clear policies, procedures, and practices that support secure, organized and confidential management of information, to include electronic individual records if applicable.
 - Maintenance and transfer of both written and spoken information is addressed:
 - 1. Personal individual information;
 - 2. Billing information; and
 - 3. All service related information.
 - The provider has a Confidentiality and HIPAA Privacy policy that clearly addresses state and federal confidentiality laws and regulations. The provider has a Notice of Privacy Practices that gives the individual adequate notice of the provider's policies and practices regarding use and disclosure of their Protected Health Information. The notice must contain mandatory elements required by the Health Insurance Portability and Accountability Act of 1996 (HIPAA, Title II). In addition, the provider must address:
 - 1. HIPAA Privacy Rules, as outlined at 45 CFR Parts 160 and 164 are specifically reviewed with staff and individuals:
 - 2. Appointment of the Privacy Officer;
 - 3. Training to be provided to all staff:
 - 4. Posting of the Notice of Privacy Practices in a prominent place;
 - 5. Maintenance of the individual's signed acknowledgement of receipt of Privacy Notice in their record.
 - A record of all disclosures of Protected Health Information (PHI) must be kept in the medical record, so that the provider can provide an accounting of disclosures to the individual for 6 years from the current date. The record must include:
 - 1. Date of disclosure;
 - 2. Name of entity or person who received the PHI;
 - 3. A brief description of the PHI disclosed;
 - 4. A copy of any written request for disclosure; and
 - 5. Written authorization from the individual or legal guardian to disclose PHI, where applicable.
 - Confidentiality policies include procedures for substance abuse; individual records comply with 42 CFR Part 2, Confidentiality of Alcohol and Drug Abuse Patient Records.
 - Authorization for release of information is obtained when PHI of an individual is to be released or shared between organizations or with others outside the organization. All applicable DBHDD policies and procedures and HIPAA Privacy Rules (45 CFR parts 160 and 164) related to disclosure and authorization of PHI are followed. Information contained in each release of information must include:

- 1. Specific information to be released or obtained;
- 2. The purpose for the authorization for release of information;
- 3. To whom the information may be released or given;
- 4. The time period that the release authorization remains in effect (reasonable based on the topic of information, generally not to exceed a year); and,
- 5. A statement that authorization may be revoked at any time by the individual, to the extent that the provider has not already acted upon the authorization.
- Exceptions to use of an authorization for release of information are clear in policy: viii.
 - 1. Disclosure may be made if required or permitted by law;
 - 2. Disclosure is authorized as a valid exception to the law;
 - 3. A valid court order or subpoena are required for behavioral health records:
 - 4. A valid court order and subpoena are required for substance use disorder-related records;
 - 5. When required to share individual information with the DBHDD or any provider under contract or agreement with the DBHDD for the purpose of meeting obligations to the department; or
 - 6. In the case of an emergency treatment situation as determined by the individual's physician, the chief clinical officer can release PHI to the treating physician or psychologist.
- The provider has written operational procedures consistent with legal and DBHDD requirements governing the retention, maintenance, and purging of records. These procedures must address the following requirements:
 - 1. Records must be safely secured, maintained, and retained for a minimum of six (6) years from the date of their creation or the date when last in effect (whichever is later); and
 - 2. In the event of a provider closure, adherence to Maintenance of Records for Closed Providers, 04-117
 - 3. Protocols for the disposal of records after the specified retention period; or in the event of a provider closure, subsequent to the provider's adherence to Maintenance of Records for Closed Providers, 04-
- The provider has written policy, protocols and documented practice of how information in the record is transferred when an individual transition to another provider, to include but not be limited to:
 - 1. A complete certified copy of the record to the provider who will assume service provision, which includes the individual's PHI and service related information such as current medical orders, medications, and IRP/behavior plans, as deemed necessary for continuity of care and treatment;
 - 2. In addition, unused Special Medical Supplies (SMS), funds, personal belongings, burial accounts; and
 - 3. The time frames by which transfer of documents and personal belongings will be completed.
- E. Funds Management: The personal funds of an individual are managed by the individual and are protected.
 - Policies and clear accountability practices regarding individual valuables and finances comply with all applicable DBHDD policies and Social Security Guide for Organizational and/or Representative Payees regarding management of personal needs spending accounts for individuals served.
 - Providers are encouraged to utilize persons outside the organization to serve as "representative payee" such as, but not limited to:
 - 1. Family.
 - 2. Other person of significance to the individual.
 - 3. Other persons in the community not associated with the provider.
 - The provider is able to demonstrate documented effort to secure a qualified, independent party to manage the individual's valuables and finances when the person served is unable-to manage funds and there is no other person in the life of the individual who is able to assist in the management of individual valuables or funds.
 - Individual funds cannot be co-mingled with the provider's funds or other individuals' funds.
- Research: The provider policy must state explicitly, in writing, whether or not research is conducted on individuals served by the provider.

- The provider shall follow DBHDD policies surrounding research including, but not limited to Submission, Approval, and Oversight of Research Projects using DBHDD Datasets, 25-102 and Research, Protection of Human Subjects, and Institutional Review Board (IRB), 25-101.
- The provider using unusual medication and investigational experimental drugs shall be considered to be doing research.
 - 1. Policies and procedures governing the use of unusual medications and unusual investigational and experimental drugs shall be in place:
 - 2. Policies, procedures, and guidelines for research promulgated by the DCH Institutional Review Board shall be followed;
 - 3. The research design shall be approved and supervised by a physician;
 - 4. Information on the drugs used shall be maintained including:
 - a. Drug dosage forms;
 - b. Dosage range;
 - c. Storage requirements;
 - d. Adverse reactions; and
 - e. Usage and contraindications.
 - 5. Pharmacological training about the drug(s) shall be provided to nurses who administer the medications;
 - 6. Drugs utilized shall be properly labeled.

Faith Based Organizations

- Individuals or recipients of services are informed about the following issues relative to faith or denominationally based organizations:
 - 1. Its religious character:
 - 2. The individual's freedom not to engage in religious activities;
 - 3. The individual's right to receive services from an alternative provider;
 - a. The provider shall, within a reasonable time after the date of such objection, refer the individual to an alternative provider.
- If the provider provides employment that is associated with religious criteria, the individual must be informed.
- In no case may federal or state funds be used to support any inherently religious activities, such as but not limited to religious instruction or proselytizing.
- Providers may use space in their facilities to provide services, supports, and treatment without removing religious art, icons, scriptures or other symbols.
- In all cases, rules found at 42 CFR Parts 54, 54a and 45 CFR Parts 96, 260 and 1050 Charitable Choice Provisions and Regulations: Final Rules shall apply.

Service Environment: The Service Environment Demonstrates Respect for the Persons Served and is Appropriate to the Services Provided.

- Services are provided in an appropriate environment that is respectful of persons served. The environment is:
 - i. Clean:
 - Age appropriate: ii.
 - Accessible (individuals who need assistance with ambulation shall be provided bedrooms that have access to a ground level exit to the outside or have access to exits with easily negotiable ramps or accessible lifts. The site shall provide at least two (2) exits, remote from each other that are accessible to the individuals served):
 - iv. Individual's rooms are personalized; and
 - Adequately lighted, ventilated, and temperature controlled.
- Children seventeen (17) and younger may not be served with adults unless the children are residing with their parents or legal guardians in residential programs such as the Ready for Work program.

- i. Emancipated minors and juveniles who are age 17 years may be served with adults when their life circumstances demonstrate they are more appropriately served in an adult environment.
- ii. Situations representing exceptions to this Requirement must have written documentation from the DBHDD Regional Field Office. Exceptions must demonstrate that it would be disruptive to the living configuration and relationships to disturb the 'family' make-up of those living together.
- C. There is sufficient space, equipment and privacy to accommodate:
 - i. Accessibility;
 - ii. Safety of persons served and their families or others;
 - iii. Waiting:
 - iv. Telephone use for incoming and outgoing calls that is accessible and maintained in working order for persons served or supported;
 - 1. Individuals who are deaf, deaf-blind, or hard of hearing shall have access to telecommunication equipment to communicate with those outside the service location.
 - v. Provision of identified services and supports.
- D. The environment is safe:
 - i. All local and state ordinances are addressed;
 - 1. Copies of inspection reports are available;
 - 2. Licenses or certificates are current and available as required by the site or the service.
- E. There is evidence of compliance with state and county of residence fire and life safety codes for the following:
 - i. Installation of fire alarm system meets safety code (and is both audio and visual in nature);
 - ii. Each residential setting is required to have carbon monoxide detectors when natural gas, heating oil, or a wood burning fireplace is used.
 - iii. Fire drills are conducted for individuals and staff2:
 - 1. Once a month at alternating times;
 - 2. Once annually for BH administrative or sites open one shift per day;
 - 3. Twice a year during sleeping hours if residential services;
 - 4. All fire drills shall be documented with staffing involved; and
 - 5. DBHDD maintains the right to require an immediate demonstration of a fire drill during any on-site visit.
- F. Policies, plans and procedures are in place that addresses emergency evacuation, relocation preparedness and Disaster Response. Supplies needed for emergency evacuation are maintained in a readily accessible manner, including individuals' information, family contact information and current copies of physician's orders for all individual's medications.
 - i. Plans include detailed information regarding evacuating, transporting, and relocating individuals that coordinate with the local Emergency Management Agency and at a minimum address:
 - 1. Medical emergencies;
 - 2. Missing persons;
 - a. Georgia's Mattie's Call Act provides for an alert system when an individual with developmental disabilities, dementia, or other cognitive impairment is missing. Law requires residences licensed as Personal Care Homes to notify law enforcement within 30 minutes of discovering a missing individual.
 - 3. Natural disasters known to occur, such as tornadoes, snowstorms or floods;
 - 4. Power failures:
 - 5. Continuity of medical care as required;
 - 6. Notifications to families or designees; and

² Please note: Separate fire drill policies and requirements may exist for agencies/sites that provide services to individuals other than those identified in this Manual. Should the agency or site be regulated by additional policies or accreditation, providers must conform to those that are the most stringent. For example, should a site provide both Behavioral Health and Developmental Disability services, the provider must ensure compliance with both DBHDD Developmental Disabilities standards in addition to meeting the requirements outlined above.

- 7. Continuity of Operation Planning to include identifying locations and providing a signed agreement where individuals will be relocated temporarily in case of damage to the site where services are provided (for more information: http://www.georgiadisaster.info/).
- 8. CSUs are required to plan for common medically required special diets when planning emergency food supplies.
- ii. Emergency preparedness notice and plans are:
 - 1. Reviewed annually;
 - 2. Tested at least quarterly for emergencies that occur locally on a less frequent basis such as, but not limited to flood, tornado or hurricane;
 - 3. Drilled with more frequency if there is a greater potential for the emergency.
- G. Providers must comply with federal Public Law 103-227 which requires that smoking not be permitted in any portion of any indoor facility owned, leased, or contracted by the provider and used routinely or regularly for the provision of health care for youth under the age of 18. MHBG, SAPTBG
- H. Residential living support service options;
 - i. Are integrated and established within residential neighborhoods;
 - ii. Are single family units;
 - iii. Have space for informal gatherings;
 - iv. Have personal space and privacy for persons supported;
 - v. Are understood to be the "home" of the person supported or served.
 - vi. Providers who serve individuals who are deaf, deaf-blind, or hard of hearing shall have an appropriate visual alert system for front door, bedroom, and bathroom;
 - vii. Establish temperature parameters (34 to 40 degrees Fahrenheit) for the safe storage of food.
 - viii. Must maintain an emergency water supply to include at least one gallon of water per person per day for 3 days in the event of a disaster;
 - ix. Each residence is required to have fire extinguishers on each level of the residence and in the basement, if applicable.
- I. Video cameras may be used in common areas of programs that are not personal residences such as Crisis Stabilization Units where visualization of blind areas is necessary for an individual's safety. Cameras <u>may not be</u> used in the following instances:
 - i. In an individual's personal residence;
 - ii. In lieu of staff presence; or
 - iii. In the bedroom of individuals.
- J. There are policies, procedures, and practices for transportation of persons supported or served in residential services and in programs that require movement of persons served from place to place.
 - i. Policies and procedures apply to all vehicles used, including:
 - 1. Those owned or leased by the provider;
 - 2. Those owned or leased by subcontractors; and
 - 3. Use of personal vehicles of staff.
 - ii. Policies and procedures include, but are not limited to:
 - 1. Authenticating licenses of drivers, proof of insurance, and routine vehicle maintenance;
 - 2. Requirements for evidence of driver training:
 - 3. Safe transport of persons served;
 - 4. Requirements for maintaining attendance of person served while in vehicles;
 - 5. Safe use of lift:
 - 6. Availability of first aid kits;
 - 7. Fire suppression equipment; and
 - 8. Emergency preparedness.
- K. Access is promoted at service sites deemed as intake, assessment or crisis programs through:

- i. Clearly labeled exterior signs; and
- ii. Other means of direction to service and support locations as appropriate.
- L. Community services (other than Community Transition Planning) may **not** be provided in an Institution for Mental Diseases (IMD, e.g., state or private psychiatric hospital, psychiatric residential treatment facility or Crisis Stabilization Unit with greater than 16 beds), jail, youth development center (YDC) or prison system.
- M. Services may not be provided and billed for individuals who are involuntarily detained in Regional Youth Detention Centers (RYDCs) awaiting criminal proceedings, penal dispositions, or other involuntary detainment proceedings. Any exception to this requires supporting documentation from the DJJ partners. The provider holds the risk for assuring the youth's eligibility.
- 5. Infection Control: Practices are Evident in Service Settings.
 - A. The provider, at a minimum, has a basic Infection Control Plan that includes the following:
 - i. Standard Precautions:
 - ii. Hand washing protocols;
 - iii. Guidelines for the proper disposal of biohazards, such as needles, lancets, scissors, tweezers, and other sharp instruments; and
 - iv. Management of common illness likely to be emergent in the particular service setting.
 - B. The provider has effective cleaning and maintenance procedures sufficient to maintain a sanitary and comfortable environment that prevents the development and transmission of infection.
 - C. The provider adheres to policies and procedures for controlling and preventing infections in the service setting. Staff is trained and monitored to ensure infection control policies and procedures are followed.
 - D. All staff adheres to standard precautions and follows the provider's written policies and procedures in infection control techniques.
 - E. The provider's infection control plan is reviewed annually for effectiveness and revision, if necessary.
 - F. The provider has available the quantity of bed linens and towels, etc. essential for the proper care of individuals at all times. These items are washed, stored, and transported in a manner that prevents the spread of infection.
 - G. Routine laundering of an individual's clothing and personal items is done separately from the belongings of other individuals.
 - H. Procedures for the prevention of infestation by insects, rodents or pests shall be maintained and conducted continually to protect the health of individuals served.
 - I. The provider ensures that an individual's personal hygiene items, such as toothbrushes, hairbrushes, razors, nail clippers, etc., are maintained separately and in a sanitary condition.
 - J. Any pets living in the service setting must be in compliance with local, state, and federal requirements.
- 6. Medications: Providers having Oversight for Medication or that Administer Medication Follow Federal and State Laws, Rules, Regulations and Best Practice Guidelines.
 - A. A copy of the physician (s) order or current prescription dated/signed within the past year is placed in the individual's record for every medication administered or self-administered with supervision. These include:
 - i. Regular, on-going medications;
 - ii. Controlled substances;
 - iii. Over-the-counter medications;

- iv. PRN (when needed) medications; or
- v. Discontinuance order.
- A valid physician's order must contain:
 - i. The individual's name:
 - ii. The name of the medication:
 - iii. The dose:
 - iv. The route;
 - v. The frequency:
 - vi. Special instructions, if needed; and
 - vii. The physician's signature.
 - viii. A copy of the Medical Office Visit Record with the highlighted physician's medication order may also be kept as documentation.
- The order for and administration of medication must be completed by members of the medical staff pursuant to the Medical Practice Act of 2009, Subsection 43-34-23 Delegation of Authority to Nurse and Physician Assistant and must be administered by licensed or credentialed* medical personnel under the supervision of a physician or registered nurse in accordance with O.C.G.A.
- The provider has written policies, procedures, and practices for all aspects of medication management including, but not limited to:
 - i. Prescribing: requires the comparison of the physician's medication prescription to the label on the drug container and to the Medication Administration Record (MAR) to ensure they are all the same before each medication is administered or supervised self-administration is done.
 - ii. Ordering: describes the process by which medication orders are filled by a pharmacy.
 - iii. Authenticating orders describes the required time frame for actual or faxed physician's signature on telephone or verbal orders accepted by a licensed nurse.
 - iv. Procuring medication and refills: procuring initial prescription medication and over-the-counter drugs within twenty-four hours of prescription receipt, and refills before twenty-four hours of the exhaustion of current drug
 - v. Labeling: includes the Rights of Medication Administration.
 - vi. Storing: includes prescribed medications, floor stock drugs, refrigerated drugs, and controlled substances.
 - vii. Security: signing out a dose for an individual, and at a minimum, a daily inventory for controlled medications and floor stock medications; and daily temperature logs for locked, refrigerated medications are required.
 - viii. Storage, inventory, dispensing and labeling of sample medications requires documented accountability of these substances at all stages of possession.
 - ix. Dispensing: Describes the process allowed for pharmacists and/or physicians only. Includes the verification of the individual's medications from other agencies and provides a documentation log with the pharmacist's or physician's signature and date when the drug was verified.
 - x. Supervision of individual self-administration includes all steps in the process from verifying the physician's medication order to documentation and observation of the individual for the medication's effects. Makes clear that staff members may not administer medications unless licensed to do so, and the methods staff members may use to supervise or assist, such as via hand-over-hand technique, when an individual self-administers his/her medications.
 - xi. Administration of medications includes all aspects of the process to be done from verifying the physician's medication order, to who can administer the medications, to documentation and observation of the individual for the medication's effects. Administration of medications may be done only by those who are licensed in this
 - xii. Recording: includes the guidelines for documentation of all aspects of medication management. This includes adding and discontinuing medication, charting scheduled and as needed medications, observations regarding the effects of drugs, refused and missing doses, making corrections, and a legend for recording. The legend includes initials, signature, and title of staff member.

- xiii. Disposal of discontinued or out-of-date medication includes an environmentally friendly method or disposal by pharmacy.
- xiv. Education to the individual and family (as desired by the individual) regarding all medications prescribed and documentation of the education provided in the clinical record.
- xv. All PRN or "as needed" medications will be accessible for each individual as per his/her prescriber(s) order(s) and as defined in the individuals' IRP. Additionally, the provider must have written protocols and documented practice that ensures safe and timely accessibility that includes, at a minimum, how medication will be stored, secured or need refrigeration when transported to different programs and home visits.
- E. Organizational policy, procedures and documented practices stipulate that:
 - i. Medical conditions are assessed, monitored, and recorded. This includes but is not limited to situations in which:
 - 1. Medication or other ongoing health interventions are required;
 - 2. Chronic or confounding health factors are present;
 - 3. Medication prescribed as part of DBHDD services has research indication necessary surveillance of the emergence of diabetes, hypertension, and/or cardiovascular disease;
 - 4. Allergies or adverse reactions to medications have occurred; or
 - 5. Withdrawal from a substance is an issue.
 - ii. In homes licensed as Community Living Arrangements (CLA)/Personal Care Homes (PCH), staff may administer medications in accordance with CLA Rules 290-9-37.01 through .25 and PCH Rules 111-8-62.01 through .25.
 - iii. Only physicians or pharmacists may re-package or dispense medications.
 - 1. This includes the re-packaging of medications into containers such as "day minders" and medications that are sent with the individual when the individual is away from his residence.
 - 2. Note that an individual capable of independent self-administration of medication may be coached in setting up their personal "day minder."
 - iv. There are safeguards utilized for medications known to have substantial risk or undesirable effects, including but not limited to:
 - 1. Storage;
 - 2. Handling;
 - 3. Ensuring appropriate lab testing or assessment tools accompany the use of the medication; and
 - 4. Obtaining and maintaining copies of appropriate lab testing and assessment tools that accompany the use of the medications prescribed from the individual's physician for the individual's clinical record, or at a minimum, documenting in the clinical record the requests for the copies of these tests and assessments; and follow-up appointments with the individual's physician(s) for any further actions needed.
 - v. Education regarding the risks and benefits of the medication is documented and explained in language the individual can understand. Medication education provided by the provider's staff must be documented in the clinical record. Informed consent for the medication is the responsibility of the physician; however, the provider obtains and maintains copies of these informed consent documents, or at a minimum, documents its request for copies of these in the clinical record.
 - vi. Where medications are self-administered, protocols are defined for training to support individual self-administration of medication.
 - vii. Staff is educated regarding:
 - 1. Medications taken by individuals, including the benefits and risk;
 - 2. Monitoring and supervision of individual self-administration of medications;
 - 3. The individual's right to refuse medication; and
 - 4. Documentation of medication requirements.
 - viii. There are protocols for the handling of licit and illicit drugs brought into the service setting. This includes confiscating, reporting, documenting, educating, and appropriate discarding of the substances.
 - ix. Requirements for safe storage of medication are as required by law includes:
 - 1. Single and double locks,
 - 2. Shift counting of the medications,
 - 3. Individual dose sign-out recording,
 - 4. Documented planned destruction,

- 5. Refrigeration and daily temperature logs with temperature parameters set at 36 to 41 degrees Fahrenheit for the safe storage of medications.
- x. The provider defines requirements for timely notification to the prescribing professional regarding:
 - 1. Drug reactions;
 - 2. Medication problems;
 - 3. Medication errors: and
 - 4. Refusal of medication by the individual.
- xi. When the provider allows verbal orders from physicians, those orders will be authenticated:
 - 1. Within 72 hours by fax with the physician's signature on the page (including electronic signature); and
 - 2. The fax must be maintained in the individual's record;
- xii. There are practices for regular and ongoing physician review of prescribed medications including, but not limited to:
 - 1. Appropriateness of the medication;
 - 2. Documented need for continued use of the medication;
 - 3. Monitoring of the presence of side effects. Individuals on medications likely to cause tardive dyskinesia are monitored at prescribed intervals using an Abnormal Involuntary Movement Scale (AIMS testing);
 - Monitoring of the rapeutic blood levels, if required by the medication such as Blood Glucose testing, Dilantin blood levels and Depakote blood levels; such as kidney or liver function tests;
 - 5. Ordering specific monitoring and treatment protocols for diabetic, hypertensive, seizure disorder, and cardiac individuals, especially related to medications prescribed and required vital sign parameters for administration;
 - 6. Writing medication protocols for specific individuals in homes licensed as Community Living Arrangements or Personal Care Homes for identified staff members to administer:
 - a. Epinephrine for anaphylactic reaction;
 - b. Insulin required for diabetes;
 - c. Suppositories for ameliorating serious seizure activity; and
 - d. Medications through a nebulizer under conditions described in the Community Living Arrangement Rule 290-9-37-.20 (2).
 - 7. Monitoring of other associated laboratory studies.
- xiii. For providers that secure their medications from retail pharmacy and/or employ a licensed pharmacist, there is a biennial assessment of agency practice of management of medications at all sites housing medications. A licensed pharmacist or licensed registered nurse conducts the assessment. The report shall include, but may not be limited to:
 - 1. A written report of findings, including corrections required;
 - 2. A photocopy of the license of the pharmacist and/or registered nurse; and
 - 3. A statement of attestation from the licensed pharmacist or licensed Registered Nurse that all issues have been corrected.
- xiv. For providers that conduct any laboratory testing on-site, documented evidence is provided that the provider's Clinical Laboratory Improvement Amendment (CLIA) Waiver is current. Refer to the list of waived tests updated April 15, 2010 on the Centers for Medicaid and Medicare Services website.
- The "Eight Rights" for medication administration are defined with detailed guidelines for staff to implement within the organization to verify that right:
 - i. Right person: includes the use of at least two identifiers and verification of the physician's medication order with the label on the prescription drug container and the MAR entry to ensure that all are the same every time before a medication is taken via self-administration or administered by a licensed staff member.
 - ii. Right medication: includes verification of the medication order with the label on the prescription drug container and the MAR entry to verify that all are the same every time before a medication is taken via selfadministration or administered by a licensed staff member. The medication is inspected for expiration date. Insulin must be verified with another person prior to administering.
 - iii. Right time: includes the times the provider schedules medications, or the specific physician's instructions related to the drug.
 - iv. Right dose: includes verification of the physician's medication order of dosage amount of the medication; with the label on the prescription drug container and the Medication Administration Record entry to ensure that all

are the same every time before a medication is taken via self-administration or administered by a licensed staff member. The amount of the medication should make sense as to the volume of liquid or number of tablets to be taken.

- v. Right route: includes the method of administration.
- vi. Right position: includes the correct anatomical position; individual should be assisted to assume the correct position for the medication method or route to ensure its proper effect, instillation, and retention.
- vii. Right documentation includes proper methods of the recording on the MAR; and
- viii. Right to refuse medications: includes staff responsibilities to encourage compliance, document the refusal, and report the refusal to the administration, nurse administrator, and physician.
- G. A Medication Administration Record (MAR) is in place for each calendar month that an individual take or receives medication(s):
 - Documentation of routine, ongoing medications occur in one discreet portion of the MAR and include but may not be limited to:
 - 1. Documentation by calendar month that is seguential according to the days of the month:
 - 2. A listing of all medications taken or administered during that month including a full replication of information in the physician's order for each medication:
 - a. Name of the medication;
 - b. Dose as ordered:
 - c. Route as ordered:
 - d. Time of day as ordered; and
 - e. Special instructions accompanying the order, if any, such as but not limited to:
 - i. Must be taken with meals;
 - ii. Must be taken with fruit juice;
 - iii. May not be taken with milk or milk products.
 - 3. If the individual is to take or receive the medication more than one time during one calendar day, each time of day must have a corresponding line that permits as many entries as there are days in the month:
 - 4. All lines representing days and times preceding the beginning or ending of an order for medications shall be marked through with a single line;
 - 5. When a physician discontinues (D/C) a medication order, that discontinuation is reflected by the entry of "D/C" at the date and time representing the discontinuation followed by a mark through of all lines representing days and times that were discontinued.
 - ii. Documentation of medications that are taken or received on a periodic basis, including over the counter medications, occur in a separate discreet portion of the MAR and include but may not be limited to:
 - 1. A listing of each medication taken or received on a periodic basis during that month including a full replication of information in the physician's order for each medication:
 - a. Name of the medication;
 - b. Dose as ordered;
 - c. Route as ordered;
 - d. Purpose of the medication;
 - e. Frequency that the medication may be taken:
 - i. The date and time the medication is taken or received is documented for each use.
 - ii. When 'PRN' or 'as needed' medication is used, the PRN medications shall be documented on the same MAR after the routine medications and clearly marked as "PRN" and the effectiveness is documented.
 - iii. Each MAR shall include a legend that clarifies:
 - 1. Identity of authorized staff initials using full signature and title;
 - 2. Reasons that a medication may be not given, is held or otherwise not received by the individual, such as but not limited to:

"H" = Hospital

"R" = Refused

"NPO" = Nothing by mouth

"HM" = Home Visit

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"DS" = Day Service

7. Waiver of Requirements

A. The provider may not exempt itself from any of these requirements or any portion of the Provider Manual. All requests for waivers of these requirements must be done in accordance with policy: Requests for Waivers of the Standards/Requirements for Mental Health, Developmental Disabilities and Addictive Diseases.

COMMUNITY SERVICE REQUIREMENTS FOR ALL PROVIDERS SECTION II: STAFFING REQUIREMENTS

1. General Staffing Requirements

- A. The professional(s) attached to the organization should have experience in the field of expertise best suited to address the needs of the individual(s) served.
- B. Providers must ensure an adequate staffing pattern to provide access to services.:
 - i. Please reference the staffing requirements specified for Tier 1 (CCP Standard 10 Required Staffing, 01-210) and Tier 2 (CMP Standard 8 Required Staffing, 01-238), and Tier 2+ (CMP+ Standard 8 Required Staffing, 01-238a) providers, as appropriate.
 - ii. Providers must also reference the Service Guideline(s) of the particular service(s) being provided, and adhere to any additional staffing requirements stated therein.
- C. Organizational policy and practice demonstrate that appropriate professional staff shall conduct the following services, supports, and treatment, including but not limited to:
 - i. Overseeing the services, supports, and treatment provided to individuals;
 - ii. Supervising the formulation of the individual recovery plan, and delivery of services related to the plan;
 - iii. Designing and writing behavior support plans;
 - iv. Implementing assessment, care, and treatment activities as defined in professional practice acts; and
 - v. Supervising programs and services.
- D. The type and number of professional staff attached to the organization are:
 - i. Properly licensed or credentialed in the professional field as required;
 - ii. Present in numbers to provide adequate supervision to staff;
 - iii. Present in numbers to provide services, supports, and treatment to individuals as required; and
 - iv. Knowledgeable, experienced, and skilled in the profession they represent.
- E. The type and number of all other staff attached to the organization are:
 - i. Properly trained or credentialed in the professional field as required;
 - ii. Present in numbers to provide services, supports, and treatment to individuals as required; and
 - iii. Experienced and competent in the services, supports, and treatment they provide.
- F. A physician with experience in behavioral health must be designated/responsible for directing any medical or psychiatric services, including medically-based SUD withdrawal/management.
- G. Providers of Specialty Services must maintain support from an independently licensed clinician to provide service review, service monitoring, and assistance in directing an appropriate course of treatment. This individual may be an employee or contracted.

2. Recruitment and Training

- A. Job descriptions are in place for all personnel that include:
 - i. Qualifications for the job;
 - ii. Duties and responsibilities;
 - iii. Competencies required;
 - iv. Expectations regarding quality and quantity of work; and

- Documentation that the individual staff has reviewed, understands, and is working under a job description specific to the work performed within the organization.
- B. The provider must detail in its policies and procedures, by job classification, the following:
 - Training required during orientation; i.
 - Training that must be refreshed annually: ii.
 - Additional training required for professional level staff; and iii.
 - Additional training/recertification (if applicable) required for all other staff. iv.
- C. Direct crisis service professionals receive Deaf Crisis Services Training within 60 (sixty) days of the start of their hire. In addition, all direct crisis service professionals receive refresher training on an annual basis, thereafter. [Training Requests are emailed to DeafServices@dbhdd.ga.gov with "Deaf Crisis Services Training" in the subject line to schedule training].
- D. Unless otherwise indicated in specific service definitions, DBHDD policy, and/or other regulation, in 24-hour or residential settings, all direct care and clinical staff must be trained in Basic Life Support (BLS) and first aid. Training must be both written and hands-on competency-based.
- E. In order to be designated as a "paraprofessional" provider type, staff must comply with training requirements found later in this section, entitled the "Standard Training Requirement for Paraprofessionals."
- F. All staff, direct support volunteers, and direct support consultants shall be trained and show evidence of competence as indicated in the below chart titled Training Requirements for all Staff, Direct Support **Volunteers, and Direct Support Consultants:**

Training Requirements for all Staff, Direct Support Volunteers, and Direct Support Consultants

Orientation requirements are specified for all staff and are provided prior to direct contact with individuals and are as follows:

- The purpose, scope of services, supports, and treatment offered including related policies and procedures;
- HIPAA and Confidentiality of individual information, both written and spoken;
- Rights and Responsibilities of individuals;
- Requirements for recognizing and reporting suspected abuse, neglect, or exploitation of any individual:
 - To the DBHDD;
 - Within the organization;
 - o To appropriate regulatory or licensing agencies; and,
 - To law enforcement agencies.

Within the first sixty (60) days from date of hire, all staff having direct contact with individuals shall receive the following training including, but not limited to:

- Person centered values, principles and approaches;
- A holistic approach to treatment of the individual;
- Medical, physical, behavioral and social needs and characteristics of the persons served:
- Human rights and responsibilities (*);
- Promoting positive, appropriate and responsive relationships with persons served, their families, and stakeholders;
- The utilization of:
 - Communication Skills (*);
 - o Crisis intervention techniques to de-escalate challenging and unsafe behaviors (*); and
 - Nationally benchmarked techniques for safe utilization of emergency interventions of last resort (if such techniques
 - o are permitted in the purview of the organization).
- Ethics, cultural preferences and awareness:
- Fire safety (*);
- Emergency and disaster plans and procedures (*);
- Techniques of Standard Precautions, including:

- Preventative measures to minimize risk of HIV;
- o Current information as published by the Centers for Disease Control (CDC); and
- Approaches to individual education.
- Current CPR/AED through the American Heart Association, Health & Safety Institute, or the American Red Cross.
 - All medically licensed staff (nurses, physicians, psychiatrists, dentists, and CNAs) are required to have the Professional Rescuers level of training (Basic Life Support for Healthcare Providers and AED or CPR/AED for the Professional Rescuer).
 - All other staff must have the Lay Rescuers level of training (Heartsaver CPR and AED or CPR/AED).
 - Staff working in CLAs must have Basic Life Support (BLS) level of training.
 - All CPR/AED training, regardless of level, includes both written and hands-on competency training.
- First aid and safety training is required for all staff as indicated above with the exception of medically licensed staff (i.e. nurses, physicians, psychiatrists, dentists, and CNAs);
- Specific individual medications and their side effects (*):
- Services, support, and treatment specific topics appropriate persons served, such as but not limited to:
 - Symptom management;
 - Principles of recovery relative to individuals with mental illness;
 - Principles of recovery relative to individuals with addictive disease;
 - Principles of recovery and resiliency relative to children and youth; and
 - Relapse prevention.

A minimum of 16 hours of training must be completed annually to include the trainings noted by an asterisk (*) above

Employee Management and Record Keeping

- A. The provider has procedures and practices for verifying licenses, credentials, and the knowledge/experience/skills of staff:
 - i. There is documentation of implementation of these procedures for all staff attached to the organization; and
 - Licenses and credentials are current as required by the field. ii.
- B. The provider has policies, procedures and documentation practices detailing all human resources practices, including but not limited to:
 - i. Processes for determining staff qualifications including license or certification status, training, experience, and competence.
 - ii. Processes for managing personnel information and records including but not limited to:
 - Criminal records checks (including process for reporting CRC status change); and
 - Driver's license checks. 2.
 - iii. Provisions for and documentation of:
 - Timely orientation and development of personnel, including the training topics enumerated above;
 - Periodic assessment and development of training needs;
 - Development of activities responding to those needs; and
 - Annual work performance evaluations.
 - Provisions for sanctioning and removal of staff when: İ۷.
 - Staff are determined to have deficits in required competencies; and
 - Staff is accused of abuse, neglect or exploitation.
- C. Regular review and evaluation of the performance of all staff is evident at least annually by managers who are clinically, administratively, and experientially qualified to conduct evaluations.

Health and Safety

A. The organization must have policies and procedures for protecting the health and safety of all staff.

- B. Specific measures to ensure the health and safety of those staff that engage in community-based service delivery activities must be identified.
- C. Must adhere to DBHDD policies regarding staff health and safety, including, but not limited to:
 - i. Accreditation and Standards Compliance Requirements for Providers of Behavioral Health Services, 01-103
 - ii. Criminal History Record Check for DBHDD Network Provider Applicants, 04-104

5. Compliance Management

- A. For any service which a provider has agreed to provide under a contract, Letter of Agreement, or Provider Agreement with DBHDD, the following rules apply:
 - i. The provider shall not enter into a contract or other arrangement with another person or agency for the provision of all or substantially all of any service.
 - ii. The provider may utilize individual independent contractors for aspects of service delivery, if the provider's use of such individual independent contractors does not violate rule (1) of this paragraph or any other applicable law, rule, or regulation, and if such use of individual independent contractors is not otherwise prohibited by DBHDD or by the Department of Community Health. However, the provider must at all times maintain administrative control and clinical direction over all persons who have direct contact with individuals served for the purpose of service delivery, whether those persons are employees, independent contractors, volunteers, or any other person acting on the provider's behalf; and the provider shall not delegate such administrative control or clinical direction to another person or agency through a contract or other arrangement.
 - iii. Any exception to rule (1) or rule (2) of this paragraph must be expressly set forth in the provider's contract, Letter of Agreement, or Provider Agreement with DBHDD.
 - iv. A provider shall not submit a bill or claim for services that have been provided in violation of any rule of this paragraph, regardless of whether those services are funded through Medicaid or through state funds.
- B. Federal law, state law, professional practice acts and in-field certification requirements are followed, including but not limited to:
 - Professional or non-professional licenses and qualifications required to provide the services offered. If it is determined that a service requiring licensure or certification by State law is being provided by an unlicensed staff, it is the responsibility of the provider to comply with <u>Professional Licensing or Certification</u> Requirements and the Reporting of Practice Act Violations, 04-101.
 - ii. Laws governing hours of work such as but not limited to the Fair Labor Standards Act.
- C. The status of students, trainees, and individuals working toward licensure must be disclosed to the individuals receiving services from trainees/ interns and signatures/titles of these practitioners must also include indication of that status.
- D. It must be evident that the provider demonstrates administration of personnel policies without discrimination.

Approved Behavioral Health Practitioners 9

Level system are noted below. These approved abbreviations must be on the signature lines in documentation where credentials are required (i.e. orders for services, progress notes, etc.). For those staff members (PP, CPS, S/T, etc.) whose practitioner level is affected by a degree, the degree initials must also be included. For example, if a Paraprofessional is working with an applicable Bachelor of Arts degree, he or she would include "PP, BA" as his or her credentials. The table below outlines the requirements of the approved behavioral health practitioners. Abbreviations for credentials recognized in the Practitioner For detail on the services each practitioner type can provide, see Practitioner Detail, Table A. Service x Practitioner Table.

Professional Title & Abbreviation for Signature Line	Minimum Level of Education/Degree / Experience Required	License/ Certification Required	Requires Supervision?	State Code
Physician (M.D., D.O., etc.)	Graduate of medical or osteopathic college	Licensed by the Georgia Composite Board of Medical Examiners	No. Additionally, can supervise others	43-34-20 to 43-34-37
Psychiatrist (M.D., etc.)	Graduate of medical or osteopathic college and a residency in psychiatry approved by the American Board of Psychiatry and Neurology	Licensed by the Georgia Composite Board of Medical Examiners	No. Additionally, can supervise others	43-34-20 to 43-34-37
Physician's Assistant (PA)	Completion of a physician's assistant training program approved by the Georgia Composite Board of Medical Examiners at least 1 year of experience in behavioral healthcare required to supervise CPRP, CPS, or PP staff	Licensed by the Georgia Composite Board of Medical Examiners	Physician delegates functions to PA through Board-approved job description.	43-34-100 to 43-34- 108
Advanced Practice Registered Nurse (APRN): Clinical Nurse Specialist/Psychiatric- Mental Health (CNS- PMH) and Nurse	R.N. and graduation from a post-basic education program for Nurse Practitioners Master's degree or higher in nursing for the CNS/PMH Nurse Practitioners must have at least 1 year of experience in behavioral healthcare to supervise CPRP, CPS, or PP staff	Current certification by American Nurses Association, American Nurses Credentialing Center or American Academy of Nurse Practitioners and authorized as an APRN by the Georgia Board of Nursing	Physician delegates advanced practice functions to APRN, CNS-PMH, NP through Board-approved nurse protocol agreements.	43-26-1 to 43-26-13, 360-32
Licensed Pharmacist (LP)	Graduated and received an undergraduate degree from a college or school of pharmacy; completed a Boardapproved internship and passed an examination.	Licensed by the Georgia State Board of Pharmacy	No	26-4
Registered Nurse (RN)	Georgia Board of Nursing-approved nursing education program at least 1 year of experience in behavioral healthcare required to supervise CPRP, CPS, or PP. OR	Licensed by the Georgia Board of Nursing OR	By a physician	43-26-1 to 46-23-13

Professional Title & Abbreviation for Signature Line	Minimum Level of Education/Degree / Experience Required	License/ Certification Required	Requires Supervision?	State Code
	A nursing education program approved by an equivalent board of nursing in a state that is a member of the Enhanced Nursing Licensure Compact (eNLC).	Licensed as an RN in an Chhanced Cursing Cicensure Compact ©CEparticipating state, and possessing an Enhanced Nursing Licensure Compact license granted by the National Council of State Boards of Nursing (NCSBN). Practice must comply with all NCSBN and Georgia Board of Nursing rules and regulations.		43-26-65 43-26-65
Licensed Practical Nurse (LPN)	Graduation from a nursing education program approved by the Georgia Board of Licensed Practical Nursing. OR Graduation from a nursing education program approved by an equivalent board of nursing in a state that is a member of the Enhanced Nursing Licensure Compact (eNLC).	Licensed by Georgia Board of Licensed Practical Nursing OR Licensed as an LPN in an _nhanced _ursing _icensure Compact	By a Physician or RN	43-26-30 to 43-26-43 43-26-60 to 43-26-65
Licensed Dietician (LD)	 Bachelor's degree or higher with a degree in dietetics, human nutrition, food and nutrition, nutrition education or food systems management. Satisfactory completion of at least 900 hours of supervised experience in dietetic practice 	Licensed by Georgia Board of Licensed Dieticians	No	43-11A-1 to 43-11A-19
Qualified Medication Aide (QMA)	Completion of a prescribed course conducted by the Georgia Department of Technical and Adult Education and pass examination for qualified medication aides approved by the Georgia Board of Licensed Practical Nursing.	Certified by the Georgia Board of Licensed Practical Nursing	Supervised by RN performing certain medication administration tasks as delegated by RN or LPN.	43-26-50 to
Psychologist (PhD or PsyD)	Doctoral Degree	Licensed by the Georgia Board of Examiners of Psychologists.	No. Additionally, can supervise others	43-39-1 to 43-39-20

Professional Title & Abbreviation for Signature Line	Minimum Level of Education/Degree / Experience Required	License/ Certification Required	Requires Supervision?	State Code
		Licensed to practice Psychology in a Psychology Interjurisdictional Compact (PSYPACT)-participating state, and possessing either an E.Passport or Interjurisdictional Practice Certificate (IPC) granted by the Association of State and Provincial Psychology Licensing Boards (ASPPB). Practice must comply with all ASPPB and Georgia Board of Examiners of Psychologists rules and regulations.		43-39-6 43-39-7 43-39-8 43-39-21 43-39-22
Licensed Clinical Social Worker (LCSW)	Master's degree in Social Work plus 3 years of supervised full-time work in the practice of social work after the master's degree.	Licensed by the Georgia Composite Board of Professional Counselors, Social Workers, and Marriage and Family Therapists	No. Additionally, can supervise others	43-10A
Licensed Professional Counselor (LPC)	Master's degree	Licensed by the Georgia Composite Board of Professional Counselors, Social Workers, and Marriage and Family Therapists	No. Additionally, can supervise others	43-10A
Licensed Marriage and Family Therapist (LMFT)	Master's degree	Licensed by the Georgia Composite Board of Professional Counselors, Social Workers, and Marriage and Family Therapists	No. Additionally, can supervise others	43-10A
Licensed Master's Social Worker (LMSW)	Master's degree in Social Work	Licensed by the Georgia Composite Board of Professional Counselors, Social Workers, and Marriage and Family Therapists	Works under direction and supervision of an appropriately licensed/credentialed professional.	43-10A
Associate Professional Counselor (May be noted as LAPC and APC)	Master's degree	Licensed by the Georgia Composite Board of Professional Counselors, Social Workers, and Marriage and Family Therapists	Works under direction and supervision of an appropriately	43-10A

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Professional Title & Abbreviation for Signature Line	Minimum Level of Education/Degree / Experience Required	License/ Certification Required	Requires Supervision?	State Code
			licensed/credentialed professional	
Associate Marriage and Family Therapist (May be noted as LAMFT and AMFT)	Master's degree	Licensed by the Georgia Composite Board of Professional Counselors, Social Workers, and Marriage and Family Therapists	Works under direction and supervision of an appropriately licensed/credentialed professional	43-10A
Certified Advanced Alcohol and Drug Counselor (CAADC) Note: ICAADC is an accepted equivalent.	Master's degree or above in human services, with a clinical application. Must meet the legal standards set forth in Georgia Code 43-10A-7. Must meet the certification criteria set forth by the certifying body and maintain certification in good standing.	Certification by the Alcohol and Drug Abuse Certification Board of Georgia (ADACB-GA); International Certification and Reciprocity Consortium /Alcohol and Other Drug Abuse (IC&RC).	Services limited to those practices sanctioned by the certifying board and Georgia Code 43-10A-7 and shall in any event be limited to the provision of chemical dependency treatment.	43-10A-7
Georgia Certified Alcohol and Drug Counselor Level III (GCADC-III)	Master's degree or above in human services, with a clinical application. Must meet the legal standards set forth in Georgia Code 43-10A-7. Must meet the certification criteria set forth by the certifying body and maintain certification in good standing.	Certification by the Alcohol and Drug Abuse Certification Board of Georgia (ADACB-GA); International Certification and Reciprocity Consortium /Alcohol and Other Drug Abuse (IC&RC).	Services limited to those practices sanctioned by the certifying board and Georgia Code 43-10A-7 and shall in any event be limited to the provision of chemical dependency treatment.	43-10A-7
Master Addiction Counselor (MAC) through the National Board of Certified Counselors (NBCC)	Master's Degree Documentation of a minimum of 12 semester hours of graduate coursework in the area of OR 500 CE hours specifically in addictions. Must meet the legal standards set forth in Georgia Code 43-10A-7. Must meet the certification criteria set forth by the certifying body and maintain certification in good standing.	Certification by the National Board of Certified Counselors (NBCC) Nationally Certified Counselor (NCC) credential – must be Licensed by the Georgia Composite Board of Professional Counselors, Social Workers, and Marriage and Family Therapists.	Services limited to those practices sanctioned by the certifying board and Georgia Code 43-10A-7 and shall in any event be limited to the provision of chemical dependency treatment.	43-10A-7

Professional Title & Abbreviation for Signature Line	Minimum Level of Education/Degree / Experience Required	License/ Certification Required	Requires Supervision?	State Code
Certified Addiction Counselor, Level I (CAC-I)	GED / high school diploma or higher. Must meet the legal standards set forth in Georgia Code 43-10A-7. Must meet the certification criteria set forth by the certifying body and maintain certification in good standing.	Certification by the Georgia Addiction Counselors' Association.	Services limited to those practices sanctioned by the certifying board and Georgia Code 43-10A-7 and shall in any event be limited to the provision of chemical dependency treatment.	43-10A-7
Certified Alcohol and Drug Counselor – Trainee (CADT-T)	High school diploma/equivalent or higher, and actively pursuing certification as a GCADC. Must meet the legal standards set forth in Georgia Code 43-10A-7. Must meet the criteria set forth by the certifying body and maintain certification trainee status in good standing. Completion of Standardized Training Requirement for Paraprofessionals approved by the Georgia Department of Community Health.	Certification by the Alcohol and Drug Abuse Certification Board of Georgia (ADACB-GA); International Certification and Reciprocity Consortium / Alcohol and Other Drug Abuse (IC&RC).	Under supervision of a Certified Clinical Supervisor (CCS), MAC, CAADC, CAC-II, GCADC-II or -III, LPC, LCSW or LMFT who have a minimum of 5 hours of Co-Occurring or Addiction specific continuing education hours per year.	43-10A-7
			Services limited to those practices sanctioned by the certifying board and Georgia Code 43-10A-7 and shall in any event be limited to the provision of chemical dependency treatment.	
Certified Counselor in Training (CCIT)	High school diploma/equivalent or higher, and actively pursuing certification as a CAC. Must meet the legal standards set forth in Georgia Code 43-10A-7. Must meet the criteria set forth by the certifying body and maintain certification trainee status in good standing. Completion of Standardized Training Requirement for Paraprofessionals approved by the Georgia Department of Community Health.	Certification by the Georgia Addiction Counselors' Association.	Under supervision of a Certified Clinical Supervisor (CCS), MAC, CAADC, CAC-II, GCADC-II or -III, LPC, LCSW or LMFT who have a minimum of 5 hours of Co-Occurring or Addiction specific continuing education hours per year.	

Professional Title & Abbreviation for Signature Line	Minimum Level of Education/Degree / Experience Required	License/ Certification Required	Requires Supervision?	State Code
			Services limited to those practices sanctioned by the certifying board and Georgia Code 43-10A-7 and shall in	
.c <u>.</u>	Hinh school dinloma/aquiivalant Associatas Dagraa	Cartified by the LIS Devohistric	provision of chemical dependency treatment.	
Certified Psychlatric Rehabilitation Professional (CPRP)	nign school diplomarequivalent, Associates Degree, Bachelor's Degree, Graduate Degree with required experience working in Psychiatric Rehabilitation (varies by level and type of degree)	Ceruned by the US Psychlatric Rehabilitation Association (USPRA, formerly IASPRS)	Under Supervision of an appropriately licensed/credentialed professional	
(CPS)	High school diploma/equivalent	Certification by the DBHDD through the Georgia Mental Health Consumer Network in accordance <u>Training and Certification of Peer Specialists, 01-123.</u>	Services shall be limited to those not requiring licensure but are provided under the supervision of an appropriately licensed/credentialed professional.	
Certified Peer Specialist-Addictive Disease (CPS-AD)	High school diploma/equivalent	Certification by the DBHDD through the Georgia Council on Substance Abuse as a CARES (Certified Addiction Recovery Empowerment Specialist) in accordance with <u>Training and</u> Certification of Peer Specialists, 01-123.	Services shall be limited to those not requiring licensure but are provided under the supervision of an appropriately licensed/credentialed professional.	
Certified Peer Specialist-Whole Health (CPS-WH) (Whole Health & Wellness Coach)	High school diploma/equivalent	Certification by the DBHDD through the Georgia Mental Health Consumer Network in accordance with <u>Training</u> and Certification of Peer Specialists. 01-123.	Services shall be limited to those not requiring licensure but are provided under the supervision of an appropriately licensed/credentialed professional.	

				43-10A
Kequires Supervision?	Services shall be limited to those not requiring licensure but are provided under the supervision of an appropriately licensed/credentialed professional.	Services shall be limited to those not requiring licensure but are provided under the supervision of an appropriately licensed/credentialed professional.	Under supervision of an appropriately licensed/credentialed professional.	Under supervision of a licensed Psychologist/LCSW, LPC, or LMFT in accordance with the GA Composite Board of Professional Counselors, Social Workers, and Marriage and Family Therapists or enrolled in a practicum with an accredited educational Master's degree program which provides supervision as a part of a
License/ Certification Required	Certification by the DBHDD through the Georgia Parent Support Network in accordance Training and Certification of Peer Specialists, 01-123.	Certification by the DBHDD through the Georgia Parent Support Network in accordance <u>Training and Certification of Peer Specialists</u> , 01-123.	Completion of a minimum of 46 hours of paraprofessional training and successful completion of all written exams and competency-based skills demonstrations.	Under supervision in accordance with the GA Composite Board of Professional Counselors, Social Workers, and Marriage and Family Therapists or enrolled in a practicum with an accredited educational Master's degree program which provides supervision as a part of a curriculum which is the foundation toward licensure
Minimum Level of Education/Degree / Experience Required	High school diploma/equivalent	High school diploma/equivalent	Completion of Standardized Training Requirement for Paraprofessionals approved by the Department of Community Health (includes training provided by the organization and online training outlined below.)	Must meet the following: 1. Minimum of a bachelor's degree; and 2. Completion of Standardized Training Requirement for Paraprofessionals approved by the Department of Community Health (includes training provided by the organization and online training outlined below); and; one or more of the following: a. Registered toward attaining an associate or full licensure; and/or b. In pursuit of a master's degree that would qualify the student to ultimately qualify as a licensed practitioner; and/or
Professional Title & Abbreviation for Signature Line	Certified Peer Specialist-Parent (CPS-P)	Certified Peer Specialist-Youth (CSP-Y)	Paraprofessional (PP)	Psychologist / LCSW / LPC / LMFT's supervisee/trainee (S/T)

· ·				
Professional litte & Abbreviation for Signature Line	Minimum Level of Education/Degree / Experience Required	License/ Certification Required	Kequires Supervision?	State Code
	c. Not registered, but is acquiring documented supervision toward full licensure i. There shall be a signed attestation by the practitioner and supervisor to be on file with personnel office; and ii. The attestation must include the anticipated and/or actual date, degree earned, licensure type (e.g., Psychologist, LCSW, LMFT, LPC), and anticipated date of licensure examination; and iii. The attestation must be updated on an annual basis.		curriculum which is the foundation toward licensure	
Vocational Rehabilitation Specialist (VS/PP or PP/VS)	Minimum of one-year verifiable vocational rehabilitation experience.	Employed by a provider that is DBHDD approved to provide ACT.	Under supervision of an ACT team leader who is either a physician, psychologist, PA, APRN, RN with a 4-year BSN, LCSW, LPC, or LMFT.	

Documentation of Supervision for Individuals Working Towards Licensure

Professional Counselors, Social Workers, and Marriage and Family Therapists for the specific professional type, whichever is shorter. In addition, the individual maintains the supervisee/trainee status for a period of no longer than 108 months, or for a period as may be specified by the Georgia Composite Board of A Psychologist/LCSW/LPC/LMFT supervisee/trainee is defined as an individual with a minimum of a Bachelor's degree, and, effective July 1, 2021, who must meet one or more of the following:

Registered toward attaining an associate or full licensure; and/or

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- In pursuit of a master's degree that would qualify the student to ultimately qualify as a licensed practitioner (Psychologist, LCSW, LMFT, LPC, LMSW, AMFT, APC); and/or
- Not registered but is acquiring documented supervision toward full licensure in accordance with O.C.G.A. 43-10A-3. Ċ

Counselors, Social Workers, and Marriage and Family Therapists (hereafter referred to as the GA Composite Board) or enrolled in a practicum with an accredited These individuals must be under supervision of a licensed Psychologist, LCSW, LPC, or LMFT in accordance with the Georgia Composite Board of Professional educational Master's degree program which provides supervision as a part of a curriculum which is the foundation toward licensure.

Students and individuals who meet the definition of a Supervisee/Trainee above do not require a co-signature on progress notes unless required by the rules of the GA Composite Board.

Providers will be required to present documentation of supervision of Supervisee/Trainees upon request by DBHDD or the DBHDD's ASO. Supervision must be In accordance with the GA Composite Board, interns and trainees must work under direction and documented clinical supervision of a licensed professional completed monthly; documentation of supervision for previous month must be in employee file by the 10th day of the following month. For example, April supervision must be recorded by February 10th.

http://sos.ga.gov/index.php/licensing/plb/43/licensure_requirements_for_professional_counselors. Documentation of supervision as defined by O.C.G.A. 43-10Aindividuals working toward licensure and it is the responsibility of the provider to ensure that the supervision requirements specified by the board for the specialty Documentation of supervision is described by O.C.G.A. 43-10A-3 as, "a contemporaneous record of the date, duration, type (individual, paired, or group), and a 3 must be present and current in personnel record. The three (3) specialties governed by the GA Composite Board have different supervision requirements for (professional counseling, social work or marriage and family therapy) for which the individual is working toward licensure are met. brief summary of the pertinent activity for each supervision session". More information can be found online at

Psychologist, LCSW, LMFT, LPC, LMSW, AMFT, APC), or who are not registered toward attaining licensure, but acquiring documented supervision toward full licensure in accordance with O.C.G.A. 43-10A-3, the provider will be required to present an attestation signed by both the supervisor and supervisee/trainee In addition, for Supervisee/Trainees who are either in pursuit of a Master's degree that would qualify the student to ultimately obtain licensure (i.e. as a which either:

- Confirms enrollment in a practicum with an accredited educational master's degree program which provides supervision as part of a curriculum which is the foundation toward licensure:
- The attestation must include the name of the program the student attends, degree to be earned, and the anticipated/actual graduation date; and The attestation must be updated on an annual basis; or
 - Confirms that supervision is being provided towards licensure in accordance with O.C.G.A. 43-10A-3. മ്
- The attestation must include graduation date, degree earned, type of licensure being sought (e.g., Psychologist, LCSW, LPC, LMFT) and the anticipated/actual date of licensure examination; and
- ii. The attestation must be updated on an annual basis.

Documentation of Supervisees/Trainees who are receiving on-site supervision in addition to the supervision that they are receiving off-site towards their licensure

- . A copy of the documentation showing supervision towards licensure, and
 - B. Documentation in compliance with the above-stated requirements.

For example, if a Supervisee/Trainee is working at Provider "A" as a supervisee-trainee and receiving supervision towards their licensure outside of Provider "A", a copy of the documentation showing supervision towards licensure must be held at Provider "A".

Documentation of Supervision of Certified Alcohol and Drug Counselor-Trainees and Certified Counselors in Training ထ

Certified Alcohol and Drug Counselor-Trainees (CADC-T) and Certified Counselors in Training (CCIT) may provide certain services under Practitioner Levels 4 the requirements in O.C.G.A. 43-10A. This is limited to the provision of chemical dependency treatment under direction and supervision of a clinical supervisor and 5 as noted in the applicable Service Guidelines. A CADC-T or CCIT may perform counseling as a trainee for a period of up to three (3) years if they meet approved by the certification body under which the trainee is seeking certification. Providers should refer to O.C.G.A. 43-10A-3 for the definitions of "direction" and "supervision". The Certified Alcohol and Drug Counselor - Trainee and Certified Counselor in Training Supervision Form³ and supporting documentation indicating compliance with the below requirements must be provided for all services provided by an CADC-T or CCIT. The following outlines the definition of supervision and requirements of clinical supervision:

- individual. It may include, without being limited to, the review of case presentations, audio tapes, video tapes, and direct observation in order to promote Supervision means the direct clinical review, for the purpose of training or teaching, by a supervisor of a specialty practitioner's interaction with an the development of the practitioner's clinical skills.
- Monthly Staff Supervision form must be present and current in personnel record. Supervision must be completed monthly; supervision form for previous month must be in employee file by the 10th day of the following month. For example, April supervision must be recorded by February 10th
 - Evidence must be available to show that supervising staff meet qualifications:.
- Ы minimum of five (5) hours of Co-Occurring or Addiction-Specific Continuing Education hours per year; certification of attendance/completion must be The following credentials are acceptable for Clinical Supervision: CCS; GCADC-II or -III; CAC-II; MAC, CAADC or LPC/ LCSW/LMFT who have a
- The CADC-T or CCIT must have a certification test date that is within three (3) years of hire as an CADC-T, and;
- The CADC-T or CCIT may not have more than three (3) years of cumulative experience practicing under supervision for the purpose of addiction certification, per GA Rule 43-10A; and
- The CADC-T or CCIT must have a minimum of four (4) hours of documented supervision monthly this will consist of individual and group supervision.

supervisee/trainees and Certified Alcohol and Drug Counselor-Trainees/Certified Counselors in Training. Psychologists in training must adhere to The DBHDD has added specificity regarding the supervision of these practitioners due to the volume of practice provided by LCSW/LPC/LMFT's the supervision requirements outlined in the Official Code of Georgia

9. Standard Training Requirement for Paraprofessionals

³ The Certified Alcohol and Drug Counselor-Trainee Supervision Form can be found in Appendix D of this Manual.

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Overview

while also providing paraprofessionals with access to information that will help them be more effective on the job. Demonstrated mastery of each topic area within Training Requirement. These trainings provide useful information necessary to fulfill requirements for delivering DBHDD behavioral health services and supports, In addition to the training requirements defined in this document, the DBHDD requires that all behavioral health paraprofessionals complete the Standard the Standard Training Requirement is necessary in order for paraprofessionals to provide both state-funded and Medicaid-reimbursable behavioral health services.

In total, each paraprofessional must complete 46 hours of training (29 hours via online courses and 17 hours provided by the provider). In addition, a set number The Standard Training Requirement for Paraprofessionals requires that paraprofessionals complete provider-based training as well as targeted, online trainings. of training hours must be dedicated to specific subject areas. The number of required training hours is by subject area as outlined below. See chart on following page for additional detail.

Subject Area	TOTAL Required Hours	Required via Online Courses	Required via Provider-Based Training
Corporate Compliance	2	1	1
Cultural Competence	2	2	0
Documentation	5	3	2
First Aid and CPR	9	0	9
Mental Illness – Addictive Disorders	8	8	0
Pharmacology & Medication Self-Admin	2	2	0
Professional Relationships	2	2	0
Recovery Principles	2	2	0
Safety/ Crisis De-escalation	10	4	9
Explanation of Services	1	0	1
Service Coordination	4	3	1
Suicide Risk Assessment	2	2	0
Total Required Hours	46	29	17

At this time, there is no annual or continued training requirement related to the Standard Training Requirement for Paraprofessionals. However, it should be noted that all providers must comply with all training requirements outlined within this Manual.

Required Online Courses for Paraprofessionals

The required online training hours and education component must be completed through the DBHDD provided online courses. Provider agencies have two options to go about accessing the required online courses:

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Option 1: DBHDD Online Courses

http://georgiamhad.training.reliaslearning.com/. For this option, in order to gain initial access to the online courses, providers must designate a Standard Training the required number of hours per Subject Area (above). Once the paraprofessional has been given a username and password by the provider's liaison, s/he can learners to complete particular courses that best fit your organization's needs. Providers must ensure that the online courses assigned will meet compliance with particular need within their organization. Your organization may decide to allow learners to choose their own courses within the required topic areas or to assign liaisons have supervisor rights and can add and delete learners from the system. The liaisons may also assign courses in the Learning Catalog based on the Requirement (STR) liaison to assign paraprofessionals for the online training. The liaison plays a key role in the successful use of the online curriculum. The All behavioral health providers who have an executed contract or agreement with DBHDD have free, 24/7 access to course content at go online and access the available courses and exams in the learning catalog.

Option 2: Individual Provider Essential/Relias Learning System

employee records on their own Essential/Relias Learning systems, rather than using the DBHDD online system. To use this option, approval must be given for providers to have access to the DBHDD approved course that were modified by Georgia DBHDD to reflect Georgia DBHDD policies and procedures. Although DBHDD provider agencies that hold separate contracts with Essential/Relias Learning⁴ may request to house Georgia DBHDD-specific courses and related the courses may change in the future, the list of courses modified by Georgia DBHDD for this purpose are indicated by an asterisk (*) in Appendix 1. By notifying DBHDD of their intention to utilize their own Essential/Relias Learning system rather than the DBHDD system, the provider agency is agreeing to the following stipulations:

- The provider agency must ask for permission before being allowed access to the DBHDD courses. Access is arranged by UGA's the Carl Vinson Institute of Government (UGA/CVIOG)
- The provider agency must let their users (employees) know that their Essential/Relias Learning training records are being held by the provider agency and not by DBHDD.
 - Because their training records are being held by the provider agency and not by DBHDD, it will take longer to transfer training records between employers as Essential/Relias Learning will be required to transfer records between systems.
 - It is the provider agency's complete and total responsibility to keep course offerings current as designated in the Provider Manual for Community Behavioral Health Providers, 01-112. Auditing will continue to be conducted based on the requirements specified in the Provider Manual.

The chart in Appendix 1 below displays the courses available within the Standard Training Requirement for Paraprofessionals which may be satisfied via the online training. A total of 29 hours of online training is required to fulfill the training requirement and many subjects offer several courses that can meet the

Providing Services as a Paraprofessional

The following individuals must complete the Standard Training Requirement in order to provide services as a paraprofessional:

- Individuals who are not licensed or do not hold an approved credential, regardless of education level. For example, an individual with a master's in social work but not a license would need to complete the Standard Training Requirement.
 - Contract employees providing outsourced services who fall within the paraprofessional criterion.

⁴ Essential/Relias Learning is the vendor who provides the online courses under contract with DBHDD. Though the name of Essential Learning has changed to Relias, the course selection has remained available

- Individuals who have not yet completed the certification process to be Certified Peer Specialists. დ 4. დ
- individuals who may be eligible in the future to be licensed or certified but who are not yet licensed or certified.
- Individuals who are working towards licensure and meet the qualifications of a Supervisee/Trainee must also complete the Standard Training
- Individuals providing Psychiatric Residential Treatment Facility services but not staff providing services through foster care, Intensive Community Support Program, and child & adolescent group homes. ပ

Paraprofessional staff members must complete the Standard Training Requirements within the new hire orientation guidelines for their organization but no later than 90 days after hire. Staff may provide and bill for services during these 90 days. If the Standard Training Requirement is not completed after 90 days, the individual may not bill until the requirement is fulfilled. Any services that are provided outside of the 90-day grace period by an uncertified paraprofessional subject to recoupment.

paraprofessional is an approved practitioner). In order to do so s/he must have completed the Standard Training Requirement. When documenting this service, the noted credential of the practitioner must match the practitioner level billed. For example, if an LPN would like to provide Community Support (a service for which an LPN is not an approved practitioner), that individual could bill as a paraprofessional and would therefore need to be in compliance with the Standard If an individual would like to bill a service for which they are not an approved practitioner, that individual may bill as a paraprofessional (providing that a Training Requirement. The LPN's credentials would be documented as "LPN and PP" when billing at the paraprofessional rate.

Documentation for the Standard Training Requirement

provider-based training as well as online training. This may be documented via a training certificate or transcript generated online by Essential/Relias Learning or Documentation of compliance must be available for each paraprofessional. An orientation agenda/checklist/spreadsheet with the name of the employee, date of topic, training, and number of hours must be available and is required for audit purposes. Proof of course completion must be kept in a personnel file for both by the in-person course instructor, and maintained in the personnel file.

Auditors may verify the information provided on the tracking sheet by viewing the training certificates. If this information is not available, services billed by the paraprofessional will be subject to recoupment. The date of hire must also be available for review.

If further questions or clarifications are needed regarding the Standard Training Requirement, please email questions to: <u>DBHDDLearning@dbhdd.ga.gov</u>

Subject Area	Courses available to fulfill online training requirement	Online Hours
Corporate Compliance (Must complete at least 1 hour of online training)	Corporate Compliance and Ethics	
Cultural Competence	Cultural Issues in Treatment for Paraprofessionals	2.25
(Must complete at least 2 hours of online training)	Cultural Competence	0.5
	Cultural Responsiveness in Clinical Practice	1.5
Documentation	Documentation for Treatment Planning	2
(Must complete at least 3 hours of online training)	Guidelines for Documentation	1.25
	Reducing Medical and Treatment Errors in Behavioral Health	2.25
	Integrated Care Treatment Planning	1
Mental Illness – Addictive Disorders	Substance Use and the Family for Paraprofessionals	-1.25
(Must choose at least 8 hours of online training)	Bipolar and Related Disorders in Youth	1.5
	Co-Occurring Disorders: An Overview for Paraprofessionals	1.25
	Overview of Serious Mental Health for Paraprofessionals	2.25
	Depressive Disorders in Children and Adolescents	1.75
	Behavioral Health Issues in Older Adults for Paraprofessionals	1.5
	Introduction to Bipolar and Depressive Disorders in Adults	1.75
	Evidence-Based Practices in Family Psychoeducation	1.25
	Supporting Recovery for Individuals with Schizophrenia	1.25
	Overview of Substance Use Disorders: Part I	1.25
Pharmacology and Medication Self Admin	Overview of Psychiatric Medications for Children and Adolescents	0.75
(Must choose at least 2 hours of online training)	Psychiatric Medications: An Overview for Paraprofessionals	1.5
Professional Relationships	Boundaries and Dual Relationships for Paraprofessionals	2.25
(Must complete at least 2 hours of online training)	Boundaries	0.5
	Navigating the Ethics of Dual Relationships for Clinicians	2
Recovery Principles	Path to Recovery	2
(Must choose at least 2 hours of online training)	Recovery Principles and Practices in Mental Health Treatment	1
	Language as a Tool to Combat Stigma	1
	WRAP One on One	1.5
Safety/Crisis De-escalation	Abuse and Neglect: What to Look for and How to Respond	1.5
((Must complete at least 4 hours of online training)	Incident Reporting	_
	Crisis Management Basics	1.5
Service Coordination	Introduction to Case Management	
(Must choose at least 3 hours of online training)	Overview of Case to Care Management	
	Overview of Supported Employment	2

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COMMUNITY SERVICE REQUIREMENTS FOR ALL PROVIDERS

SECTION III: DOCUMENTATION

1. OVERVIEW OF DOCUMENTATION

Organization or other regulatory entities. Items using the word "should," are less likely to impact payment, however, non-adherence will likely impact outlined herein do not supersede service-specific requirements. This Provider Manual may list additional requirements and standards which are service-specific; items using the word "must" indicate requirements for which non-adherence may impact payment or reimbursement via the Administrative Services The individual's record is a legal document that is current, comprehensive and includes those persons who are assessed, served, supported, or treated. There when there is a conflict, providers must defer to those requirements which are most stringent. All items in this section are DBHDD expectations, however, progress notes. These components are independent and yet must be inter-related in order to create a sound medical record. The documentation guidelines are three fundamental components of consumer-related documentation. These include assessment and reassessment; treatment/supports planning; and performance on quality and compliance reviews.1

- Documentation/information in the medical record: Ċ
- Must include the practitioner's printed name as listed on his or her practitioner's license;
- Should be Organized, Complete, Current, Meaningful, and Succinct; and
- Is managed in a manner that ensures individual confidentiality and security, while providing access and availability as appropriate.
- At a minimum, the individual's information: മ
- Must include the name of the individual, precautions, allergies (or no known allergies NKA) and "volume #x of #y" on the front of the record. Note that the individual's name, allergies and precautions must also be flagged on the medication administration record
- Must include the individual's identification and emergency contact information; :=
- Must include financial and insurance information necessary for adherence to Requirements to Access DBHDD Funds for Child & Adolescent Behavioral Health Services, 01-106; ≔
- Must include the following rights, consent, and legal information: .≥
- Consent for service:
- Release of information documentation;
- -egal documentation establishing guardianship;
- Evidence that individual rights and responsibilities are reviewed at the start of services, and at least one time a year thereafter; and
 - Legal status as it relates to Title 37;
- Must include pertinent medical information;
- For individuals who are deaf, deaf-blind, and hard of hearing, communication documentation must include: > . ≥

- Communication Assessment Report (CAR) from the Office of Deaf Services (which carries the weight of a Service Order) per Provider Procedures for Referral and Reporting of Individuals with Hearing Loss, 15-111; ~:
- Action plan for implementing required communication accommodations from the CAR; and
- Record of communication accommodations provided;
- Must include evidence that the services billed are the services provided;
- Should include any psychiatric or other advanced directive, or documentation that the individual has either denied the existence of a directive or declined to have it included in their medical record; :≓ :
- Should include records or reports from previous or other current providers;
- Should include correspondence related to the individual and their Individualized Recovery Plan;
- The frequency and style of documentation should be appropriate to the frequency and intensity of services, supports, and treatment and in accordance with the Service Guideline; .≚ ∹ ∵≓
- Should include documentation of contacts with persons involved in other aspects of the individual's care, including but not limited to internal or external referrals; and ≔
- There should be a documented process for ongoing communication between staff members working with the same individuals in different programs, activities, schedules or shifts. ij
- Individual records must be maintained onsite (DBHDD approved service locations) for review for a minimum of 90 days following the last date of service or discharge date as identified by the authorization for the individual served⁵. رن ن
- appropriate) must be dated by the person signing or initialing to reflect the date on which the signature/initials occurred (e.g., no backdating, no postdating, All signatures (and initials, where appropriate) must be original, belonging to the person creating the signature or initials. Signatures (and initials, where \Box
- Special Requirements for Paper versus Electronic Health Records/Medical Records نىن
 - For providers using paper Health Records/Medical Records:
- All content that is handwritten or typed must be written in black or blue ink (red ink may be used to denote allergies or precautions);
 - All content that is handwritten or typed must be readable, decipherable, and easily discernible to all readers;
- cross-outs are allowed. A single line is used to strike an entry, and that strike must be labeled with "error", initialed, and dated. Additionally, if Recorded changes - Any corrections or alternations made to existing documentation must be clearly visible. No "white-out" or unreadable a document contains a Secure Electronic Signature, it must be linked to data in such a manner that if the data is changed the electronic signature is invalidated.

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⁵ For audit purposes, records must be presented within the timeframes indicated in the Georgia Collaborative Provider Handbook; records not submitted within stated timeframes will not be accepted by the auditors for review. Additional information related to audit procedures can be found in this Handbook available online at The Georgia Collaborative ASO website at http://www.georgiacollaborative.com/providers/prv-BH.html.

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- Ability to validate document creation date, time, and author;
- Time stamp of signatures;
- Dates, time stamps, and author(s) of any edits, amendments, or late entries;
- Ability to view the original content, prior to any editing or amendments, without deletions; and
 - Dates and time stamps for documents uploaded to the EHR/EMR.

4. 3.

2. ASSESSMENT

Individualized services, supports, care and treatment determinations are made on the basis of an assessment of needs with the individual. The individual must be informed of the findings of the assessments in a language he or she can understand.

- An initial ANSA/CANS assessment must be completed within the first 30 days of intake into all behavioral health services types, excluding CSC, CSU, and Mobile Crisis Response. Ongoing ANSA/CANS assessments must be completed as demanded by changes with an individual, as needed for eauthorization of services, and upon discharge. Ċ
- Additional assessments include, but are not limited to, the following: മ്
- Summary of central themes of presenting symptoms/needs and precipitating factors;
 - individual strengths, needs, abilities, and preferences;
 - individual's hopes and dreams, or personal life goals;
 - individual's perception of the issue(s) of concern;
- Prior treatment and rehabilitation services used and outcomes of these services; .≥ >
 - Preferences for treatment, individual choice and hopes for recovery; .<u>></u>

A current health status report, medical history, and medical screening;

- Suicide risk assessment; :≓ :
- Appropriate diagnostic tools such as impairment indices, psychological testing, or laboratory tests; .≚
 - Social and Family history; ×
- School records (for school age individuals);
- Collateral history from family or persons significant to the individual, if available.
 - Review of legal concerns including:
 - Advance directives;
 - -egal competence;
- Legal involvement of the courts;
- Legal status as it relates to Title 37; and

- Legal status as adjudicated by a court.
- How needs are to be prioritized and addressed;
- What interventions are needed, when, how quickly, in what services and settings, length of stay, and with what provider(s);
 - The step-down services; Š. <u>Š</u>
- **Biopsychosocial assessment**; × Μ
- Integrated/interpretive summary; :≣X

DIAGNOSIS

- Worker, a Licensed Marriage and Family Therapist, a Licensed Professional Counselor, a Licensed Physician, or a Physician Assistant or APRN (NP and A verified diagnosis is defined as a behavioral health diagnosis that has been provided following a face-to-face (to include telemedicine) evaluation by a professional identified in O.C.G.A Practice Acts as qualified to provide a diagnosis. These include a Licensed Psychologist, a Licensed Clinical Social CNS-PMH) working in conjunction with a physician with an approved job description or protocol. Ä
- he individual for service. After 30 days, the individual must have a verified diagnosis in order to justify planned services against the diagnostic criteria and initial engagement with the individual in order to initiate timely provision of needed services. The initial engagement is defined as the first encounter with Specific to Non-Intensive Outpatient services, for any individual newly presenting to a provider, a Diagnostic Impression is allowed for 30 days after the to continue services. [NOTE: Specialty Services generally require verified diagnoses prior to admission]. Diagnostic impressions may be provided by practitioners who are permitted by their scope of practice to do so. മ
- The diagnosing professional may rely on assessment information provided by other professionals and collateral informants (as permitted by the individual), but a face-to-face interaction between the diagnosing professional and the individual must also occur (to include telemedicine). A signature by such a person on documentation leading to or supporting a diagnostic impression does not meet this requirement for performing an assessment adequate to support assigning a behavioral health diagnosis. Ċ
- At a minimum, all diagnoses must be verified annually by one of the previously named qualified practitioners. \Box
- When diagnosing individuals who are deaf, deaf-blind, or hard of hearing, the diagnosing professional must demonstrate training, supervision, and/or consultation with a qualified professional as approved by DBHDD Office of Deaf Services. ш
- with DSM-5 and ICD-10 found in the Infant and Early Childhood Mental Health Toolkit: Georgia DC:0-5TM Crosswalk and Case Studies guide to map the appropriately used the tools in the DC:0-5 manual to assess and diagnose a young child, they should use the Georgia Crosswalk of DC:0-5 Disorders diagnosis to the Diagnostic and Statistical Manual of Mental Disorders (DSM-5) and/or to the International Statistical Classification of Diseases (ICD-10), When diagnosing children who are between the ages of four (4) and five (5) years old, providers may use the DC:0-5 TW Manual. After a clinician has which are commonly used classification systems for service billing and reimbursement purposes <u>ٺ</u>

- Documentation of the initial and annually verified diagnosis(es) must: œ.
- Clearly indicate the diagnosis(es);
- Include the following information about the diagnosing practitioner:
- The diagnosing practitioner's printed name as listed on their license(s); and
- The diagnosing practitioner's credential(s);
- Include the signature of the diagnosing practitioner; and ≘i
- Include the date of the diagnosis;
- Additional Documentation Requirements: ヹ
- must adhere to the requirements above, as well as to all Diagnostic Assessment Service Guidelines set forth in this Provider Manual, and in addition i. DBHDD providers approved to deliver the Diagnostic Assessment service (regardless of whether the service is actually billed in any individual case) must have documentation of:
- The factors considered and justification used in determining the diagnosis(es);
- The necessary information (including a summary of findings) to support the diagnosis(es);
- A face-to-face clinical assessment of the individual provided as part of the diagnostic process (this requirement may be met via the use of telemedicine).
- equirements above, as well as provide documentation of a face-to-face clinical assessment (telemedicine may be used); but are not required to DBHDD specialty providers who have a diagnosing practitioner on staff who renders diagnoses for individuals served must adhere to the basic provide documentation of the factors considered and justification used in determining the diagnosis(es), a summary of findings, or any other supporting documentation related to the diagnosis(es) or diagnostic assessment process. :=i
- DBHDD specialty providers who must obtain diagnoses from external providers (regardless of whether the external provider is a DBHDD provider) considered and justification used in determining the diagnosis(es), a summary of findings, or any other supporting documentation related to the must adhere to the basic requirements above; but are not required to provide documentation of a face-to-face clinical assessment, the factors diagnosis(es) or diagnostic assessment process. ∷≡
- Any diagnostic documentation or procedures that do not conform to the above requirements and O.C.G.A. Practice Acts may result in revocation of
- While DBHDD generally sets its eligibility and medical necessity criteria and language herein in accordance with the most current version of the DSM, it is are outlined in Appendix C. Providers will note that there are additional codes that are acceptable for claims, but that are not valid codes for authorization also acceptable to utilize an ICD diagnosis as an acceptable diagnosis in the medical record. A list of valid ICD-10 diagnosis codes for claim submission

For any diagnoses that are valid for less than one year, an assessment should be completed more often (as indicated in the current DSM). If this equirement is not met due to individual refusal or choice, documentation in the record should reflect this. ⊻.

Case 1:16-cv-03088-ELR

4. ORDER/RECOMMENDATION FOR COURSE OF TREATMENT®

- All services must be recommended ("ordered") by a licensed physician or other appropriately licensed practitioner. The practitioner(s) authorized to recommend/order specific services may be found within Part I, Section IV of this Provider Manual. Ä
- Orders may exist across multiple authorizations. œ.
- The recommendation/order for a course of treatment must specify each service to be provided and shall be reviewed and signed by the appropriately icensed practitioner(s) on or before the initial date of service. Ċ.
- There are two formats that may be used for writing a recommendation/order: \Box
- An individualized recovery/resiliency plan (IRP) which fulfills the required components listed below, can be used as a recommendation/order for the applicable authorization period for services indicated within the plan.
 - A stand-alone recommendation/order in the medical record which fulfills the required components listed below.
- Required Components of the recommendation/order include: ш
- Individual name;
- All services recommended as a course of treatment/ordered as indicated by Service Description as listed in the current DBHDD Provider Manual (see C. above):

 - Signature and credentials⁷ of appropriately licensed practitioner(s); ∷≣
- Printed or stamped name and credentials of appropriately licensed practitioner(s); .≥
- Date of signature(s). Dates written to indicate the date of a signature must only be dated by the signer; and > . ≥
 - Duration of the order for the particular service, not to exceed one year from the order date.

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⁶ Note that the following requirements apply only to recommendation/orders for services as defined in Part I of this Provider Manual. Requirements regarding orders for medication and procedures can be found in Section I of these Community Service Requirements for All Providers.

See Section II of the Community Service Standards for All Providers for additional information regarding credentials.

- that the additional pages are a continuation of the order. For example, in a 2-page order, page 2 must contain the name of the individual, a page number, Should the recommendation for course of treatment (order) cross multiple pages in a paper record, the provider is responsible for ensuring that it is clear and indication that the signature of the practitioner indicates authorization for services as noted on page 1. نيا
- Recommendation for course of treatment ("orders") may be made verbally. The required components of the verbal recommendation/order include: G.
 - The provider must have policies and procedures which govern procedures for verbal orders;
 - Recommendations/Orders must be documented in the medical record and must include:
- Individual name;
- All services recommended as a course of treatment/ordered as indicated by official group name as indicated in the current DBHDD Provider
- Printed or stamped name and credentials of appropriately licensed practitioner(s) recommending service; რ.
 - 4. Date of verbal order(s); and
- Printed or stamped name, credentials, original signature, and date signed by the staff member receiving the verbal order. Provider's policy must specify which staff can accept verbal orders for services. 5
- Verbal orders must be authenticated by the ordering practitioner's signature within seven (7) calendar days of the issuance of orders. This may be an ink,-facsimile/photocopy, or electronic signature. ≔
 - Faxed/electronic orders signed by the ordering practitioner are acceptable and a preferred alternative to verbal orders. Faxed orders must be dated upon receipt and contain the Required Components (Items 4E, i through vi above). .<u>≥</u>
- When more than one physician is involved in an individual's treatment, there should be evidence that an RN or MD has reviewed all relevant information to assure there are no contradictions or inadvertent contraindications within the services and treatment orders or plan. ヹ

5. INDIVIDUALIZED RECOVERY/RESILIENCY PLANNING

and goals. This plan sets forth the course of services by integrating the information gathered from the current assessment, status, functioning, and past treatment forth in this Manual. The IRP must be reviewed and updated at least annually, and more frequently as may be needed to reflect the individual's evolving needs develop a plan that focuses on the individual's hopes, dreams and vision of a life well-lived. Every record must contain an IRP in accordance with content set Recovery/Resiliency planning documentation is included in the individual's Individualized Recovery/Resiliency Plan (IRP). The IRP planning is intended to history into a clinically sound plan.

- An individualized resiliency/recovery plan should be developed by the individual with the guidance of an appropriate professional. The individual should direct-decisions that impact their lives. Ċ
- Others who should assist in the development of the IRP are persons who are:
- Significant in the life of the individual and from whom the individual gives consent for input;
- Involved in formal or informal support of the individual and from whom the individual gives consent for input; and

- Will deliver the specific services, supports, and treatment identified in the plan.
- For individuals with coexisting, complex and confounding needs, cross-disciplinary approaches to planning should be used. Ċ
- Individualized Recovery/Resiliency Planning should: o.
- Identify and prioritize the needs of the individual;
- Be fully explained to the individual using language he or she can understand and agreed to by the individual;
- Be driven by the individual and focused on outcomes the individual wishes to achieve (based upon assessment of the individual's hopes, dreams,
- State goals which will honor achievement of stated hopes, choice, preferences, and desired outcomes of the individual and/or family;
- Be indicative of desired changes in levels of functioning and quality of life (as defined by the individual) to objectively measure progress.
- Define goals/objectives that are individualized, specific and measurable with achievable timeframes;

.<u>=</u> .≥ >

- Include a projected plan to modify or decrease the intensity of services, supports, and treatment as goals are achieved. ≔
- Documents that may be relevant for incorporation by reference into an individualized plan could include but are not limited to:
- Medical updates as indicated by physician orders or notes;
- Addenda as required when a portion of the plan necessitates reassessment;
- A personal safety/crisis plan which directs in advance the individual's desires/wishes/plans/objectives in the event of a crisis;
- A Wellness Recovery Action Plan (WRAP), which should:
- Be discussed with the individual, and assistance offered in its development should the individual desire it; œ.
- Be completely voluntary and include a written statement to that effect. If the individual declines assistance, this should be documented in a progress note. If assistance is desired by the individual, this should also be documented in a progress note (along with the start and stop time of development activities)
- Be developed with fidelity to WRAP Values and Ethics (www.mentalhealthrecovery.com);
- Belong to the individual, who chooses where it will be kept and with whom it will be shared (Is in the clinical record only if self-directed by individual with WRAP development and the fact that the individual chose to not include it in their record should be documented in the individual for inclusion). If a copy of the WRAP is not to be included in the clinical record, documentation of assistance to the ပ်ဗ
 - Be devoid of clinical language (i.e., is in the person's own language);
- Individualized plans (or portions of the plan) must be reassessed as needed, in accordance with changing needs, circumstances, and responses of the individual, including but not limited to: ш
 - Any life change that potentially impacts goals, objectives and/or interventions in the plan, or that would necessitate the addition of new goals, objectives and/or interventions;
- Any change in medical, behavioral, cognitive, and/or physical status that potentially impacts goals, objectives and/or interventions in the plan, or that would necessitate the addition of new goals, objectives and/or interventions;

- When either of the following events occur: (1) The provider refers an individual to an acute level of behavioral health care (e.g. ED for a psychiatric discharge from an acute level of behavioral health care service (regardless of whether or not the individual was enrolled with the provider prior to emergency, BHCC, Crisis Stabilization Unit, psychiatric inpatient hospital, PRTF, etc.), or (2) Within seven (7) business days of an individual's the acute care service episode, or the individual's length of stay in the acute care service), the provider must adhere to the following: ∷≡
- A licensed (independent or associate-level), or SUD-credentialled (certification level II or above) practitioner must conduct a clinical review of the individual's relevant clinical information:
- as review should include a review of the individual's clinical record (if the individual was previously enrolled with the provider), as well documentation from the acute care provider (e.g. the discharge plan or summary, the treatment plan while in acute care, any risk individual's current needs, challenges, strengths, progress, possible antecedents to the acute care episode, and post-discharge For individuals being admitted/readmitted to the provider's services following discharge from an acute level of care, this clinical assessments, the CSSRS, etc.), and any communications with the acute care provider in order to assess and address the treatment recommendations.
- For individuals being referred by the provider to an acute level of care, this clinical review should include a review of the individual's strengths, progress, possible antecedents to the acute care referral, and to develop recommendations for post-acute care services clinical record (e.g. progress notes, event notes, recent assessments, etc.), as well as communication with other practitioners or informal supports (such as family) involved in the individual's care in order to assess the individual's current needs, challenges, and supports. ď
- Based upon this clinical review, the practitioner must document their findings and recommendations in the individual's clinical record as an administrative citation, and should also specifically include any recommended modifications/additions to the IRP. <u>ە</u>
- resulting recommendations. Justification for any recommendations not adopted should be documented in a progress note. When requested by the c. Modifications/additions to the IRP must be made by a practitioner authorized to do so, as soon as possible following the clinical review and individual: .≥
- As required by a specific Service Definition;
- As required by a new or modified Order; .<u>=</u>
- At least annually; and/or
- When goals are not being met, this should be viewed as an indication that a reassessment is needed. ; ;
- When services are provided to youth during school hours, the IRP should indicate how the intervention has been coordinated among family system, school, and provider. <u>.</u>
- Individualized Recovery/Resiliency Planning must: <u>ග</u>
- Support the individual to develop goals/objectives that are:
 - Related to assessment/reassessment;
- Designed to ameliorate, rectify, correct, reduce or make symptoms manageable; and to support and utilize the individual's strengths.
 - Detail interventions which will assist in achieving the outcomes noted in the goals/objectives; := :≡
- ntensity of the service/intervention, and the overall duration of the service/intervention should be based upon what is realistic for the individual and Identify services and interventions of the right frequency, intensity and duration to best accomplish plan objectives. The frequency of delivery, the

- 1. It is expected that the actual frequency, intensity, and duration of service delivery will closely approximate the levels of service delivery projected in the IRP, and that updates to the plan will be made should the individual's needs change.
- Crisis Intervention is an exception to the requirements above, in that: The Individualized Recovery/Resiliency Plan may indicate that the Crisis Intervention service is provided as needed. If Crisis Intervention is a part of the services outlined in the IRP, it is expected that an initial and brief Crisis Plan be developed and in place in order to direct the crisis service. The Crisis Plan should conform to standards set forth in this manual.
- Identify staff responsible to deliver or provide the specific service, support, and treatment. Identification of staff can be broadly defined such as physician," "therapist," "paraprofessional," "PSR team," etc.; .<u>≥</u>
- Assure there is a goal/objective that is consistent with the service intent; and
- Document by individual signature and/or, when applicable, guardian signature that the individual served is an active participant in the planning and process of services (to the degree to which that is possible). Subsequent changes to the plan should also document individual and/or guardian signature via dated nitials. If gaining signatures or initials (as applicable) is not possible, the record should document the attempt and reason. > . ≥

6. DISCHARGE/TRANSITION PLANNING

- Discharge/transition planning should: Ċ
- Document transition planning at the onset of service delivery and includes specific objectives to be met prior to decreasing the intensity of service or discharge.
- Define discharge criteria which objectively measures progress by aligning with documented goals/objectives, desired changes in levels of functioning, and quality of life;
- Define specific step-down service/activity/supports to meet individualized needs; ∷≝
- Be measurable and include anticipated step-down/transition date.
- in or being referred to their community services by a DBHDD-operated or contracted psychiatric inpatient facility. The DBHDD contracted Comprehensive Providers of community adult behavioral health services shall participate in the hospital recovery planning team meetings for individuals currently enrolled Community Providers (CCP) and/or DBHDD Specialty Providers are held responsible and accountable for the implementation of Follow-up for Individuals Discharged from the State Hospital, 01-508. B.
- It is the provider's responsibility to discharge individuals in a timely manner once it has been determined they are no longer, or will no longer be receiving Ċ
- Residential Detox). When an individual leaves one of these HLOC services, providers are required to submit a discharge record in the Georgia i. This includes discharging individuals from the Higher Level of Care (HLOC) services (Community Inpatient, Crisis Stabilization, PRTF, and Collaborative ASO system so that a date of discharge, clinical, and discharge information can be collected. Providers shall submit this

documentation within the timeframe defined for the particular service in the DBHDD contract for the service or in this Provider Manual's Service Guidelines.

- For all other community-based services, it is the provider's responsibility to discharge individuals once the individual has left all services and will no sequence of concurrent authorization requests. Once an individual is no longer receiving any services, the provider shall report a discharge longer be returning. An episode of care begins at the point the individual is first enrolled in services and continues for as long as there is a notifying that the person is no longer being served by DBHDD.
- If at any point in time there is an authorization that has expired, and more than 90 days has passed without the provider entering a new request for services or properly discharging the individual, the Georgia Collaborative ASO will automatically generate an administrative discharge record for that individual ≡

7. DISCHARGE SUMMARY

- At the time of discharge, a summary should be provided to the individual which indicates: Ċ
- Strengths, needs, preferences and abilities of the individual;
- Services, supports, and treatment provided; and
- Outcome of the goals and objectives made during the service provision period.
 - Necessary plans for referral; and
- Service or organization to which the individual was discharged, if applicable.
- A summary of the course of services, supports, treatment, the Discharge Summary, must be placed in the record within 30 days of discharge. Documentation must include/adhere to the items in the above section entitled, "Discharge/Transition Planning," and include: മ്
- Strengths, needs, preferences and abilities of the individual;
- Services, supports, and treatment provided;
- Outcome of the goals and objectives made during the service provision period; :≝ .≥
 - Document the reason for ending services;
- Living situation at the time of discharge; >
- Necessary plans for referral; and
- Service or organization to which the individual was discharged, if applicable. .≥. :≧

PROGRESS NOTES **∞**

Progress Note documentation includes the actual implementation and outcome(s) of the designated services in an individual's IRP. There are clear requirements related to the content, components, required characteristics, and format of progress note documentation.

criteria and support all requirements for billing and adjudication of the service claims. Review of sequential progress notes should provide a snapshot of the The content in progress note documentation provides all the necessary supporting evidence to justify the need for the services based on medical necessity individual over a specified time frame.

This section is applicable to progress notes for all billed services (e.g. face-to-face, telemedicine, collateral, etc.). Note:

- Ċ
- Progress note documentation must reflect the following:

 i. Linkage Clear link between the Individualized Recovery/Resiliency Plan and intervention(s) provided.
- Consumer profile Description of the current status of the individual. This may include individual statements, shared information and quotes; observations and description of individual affect; behaviors; symptoms; and level of functioning.
- Justification Documentation must reflect justification for payment of services provided and utilization of resources as it relates to the service definition and the needs/desires of the individual. ∷≡
 - Specific services/intervention/modality provided Specific detail of all provided activity(ies) or modality(ies) including date, time, frequency, duration, and location. .≥
- Consumer response to intervention(s) Identification of how and in what manner the service, activity, and modality have impacted the individual; what was the effect; and how was this evidenced. >
 - Consumer's progress Identification of the individual's progress (or lack of progress) toward specific goals/objectives. .<u>=</u>
- Progress note documentation should reflect the following: മ
- Purpose or goal of the services/intervention/modality Clarification of the reasons the individual is participating in the above services, activities, and modalities and the demonstrated value of services.
- Monitoring Evidence that selected interventions and modalities are occurring and monitored for expected and desired outcomes.
 - Next steps Targeted next steps in services and activities to support progress toward goals/objectives in the IRP. ∷
- Reassessment and Adjustment to plan Review and acknowledgement as to whether there is a need to modify, amend or update the individualized service/recovery plan and if so, how. .≥
- manuals and/or documentation instruction sheets. All formats require a clear link between the progress note, assessment and service and planning consistently throughout their organization. Specific details regarding actual practice should be described in providers' policies, procedures, training Standardized format - Providers are expected to follow best practices and select a format or create a prescribed narrative that can be used >
- Progress note documentation must address and adhere to the following⁸: Ċ
- specific intervention. In addition, other ancillary or non-billable services which are related to the well-being of the individual served must be included Presence of note – For any claim or encounter submitted to DBHDD or DCH for these services herein, a note must be present justifying that in the individual's official medical record.

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⁸ Any electronic records process shall meet all requirements set forth in this document.

- documenting practitioner modifiers, the modifier must indicate the reimbursement level, which may differ from the practitioner level in certain cases. For example, if a RN provides CSI, the RN would include the modifier U4 to indicate the practitioner level even though an RN is generally a level 2 Service billed - All progress notes must contain the corresponding HCPCS/CPT code, which must include any designated modifier. When :=
- frame set by provider policy not to exceed seven (7) calendar days. Best practice standards require progress notes to be written within 24 hours of Timeliness - All activities/services provided are documented (written and filed) within the current individual record within a pre-established time the clinical or therapeutic activity. Notes entered retroactively into the record after an event or a shift must be identified as a "late entry" ∷≡
- Conciseness and clarity Clear language, grammar, syntax, and sentence structure is used to describe the activity and related information. .≥ >
 - Activities dated Documentation specifies the date/time of service.
- the actual date of service). Dates written to indicate the date of a signature may only be dated by the signer. In electronic records, the date of entry Dated entries – All progress note entries are dated to reflect the date of signature of the individual providing the service (this date may differ from must reflect the date that the secure electronic signature was entered. Back-dating and post-dating are not permitted. .<u>=</u>
 - **Duration of activities** Documentation of the duration must be noted for all services to include the number of units, times, and dates. For those applies for both face-to-face and collateral contacts. Residential services are excluded from the daily notation of time-in/time-out and must follow the specific guidelines outlined in each specific residential code. Further instruction related to the Psychosocial Rehabilitation Program and Peer services in which the unit/rate is based on time (not per contact/encounter), documentation must include time-in and time-out. This requirement Supports Program services can be found in the respective Service Guidelines. ≔

Rounding of Units -:ij

- service when an activity meets the service definition of the service billed but does not meet the full time/unit requirement. In order to bill a unit requirement. Each provider must have an internal policy regarding rounding of units. Regarding "rounding" of units, a unit may be billed for a the service is greater than or equal to 23 minutes and less than 38 minutes, then 2 units may be billed. Providers must document rounding example, a provider may bill a single 15-minute unit for a service greater or equal to 8 minutes and less than 23 minutes. If the duration of Time-based: Rounding of units is permitted when a service meeting the service definition is provided in less time than the unit increment of service, at least 50% of the time required per unit must be provided and documented by the "time-in, time-out" documentation. For practices in internal policy.
 - mathematical rounding protocols (i.e., .49 and less round down to the dollar amount below, .50 and higher round to the next dollar amount). Cost-based: DBHDD has some services which are cost-based reimbursement. In this case, rounding of cents should follow standard Provider documentation and policy shall define provider internal controls regarding this expectation. ςi

Location of intervention--:≓

- For those services that may be billed as occurring either In-Clinic or Out-of-Clinic, progress notes must reflect the location as either In-Clinic or Out-of-Clinic (unless otherwise noted in Service Guideline).
- If the intervention is In-Clinic, no further specificity is required. æ.
- enough that it can be generally understood where the service occurred (for example: "...at the individual's home," "...at the grocery If an intervention is "Out-of-Clinic," the note must reflect the specific location of the intervention; this indication must be specific store", etc.). Documenting that the service occurred "in the community" is not sufficient to describe the location. Þ.
- When services are provided to youth at or during school, documentation must indicate that the intervention is most effective when provided during school hours. ပ

Out-of-Clinic Justification and Documentation: ςi

Ь.

- established U7 "Out-of-Clinic" modifier associated with it, then generally, that U7 modifier is utilized on the service claim/encounter In some cases, an increased rate is allowed for Out-of-Clinic services. When a service is provided Out-of-Clinic and has an æ.
- practitioner travels from a clinic site to deliver community-based service interventions. "Out-of-Clinic" may only be billed when the expressly a financial billing mechanism. It allows additional reimbursement related to the loss of productivity which occurs when While the location of the intervention is required for clinical record documentation as noted above, the use of the U7 modifier is ollowing requirements and justifications exist:
- Travel by the practitioner is to a non-contiguous location;
- Travel by the practitioner is to a facility not owned, leased, controlled, or named as a service site by the agency who is billing the service (excepting visits to Shelter Plus sites);
- Travel is to a facility owned, leased, or controlled by the agency billing the service, but no more than 6 individuals are being served in the course of that day by a single practitioner in non-group services; ≔
- Travel is to a facility owned, leased, controlled, or named as a service site by the agency, but no more than 24 individuals are being served in groups at that site in the course of a day. <u>.≥</u>
- individual sessions), then the "Out-of-Clinic" rate may not be billed. In that case, none of the services provided at that location One group and/or six individual sessions per practitioner could occur in a single day and be claimed as "Out-of-Clinic" via the use of the U7 modifier. However, if either of these productivity caps is exceeded (i.e. more than one group OR more than six by the practitioner for that day qualify for "Out-of-Clinic" billing.
- websites as a clinic site, the site is a daily point of service for multiple practitioners, etc.) providers may need to do the due diligence of It should be noted: If volume or infrastructure indicates that a location or site is regularly operating as a service site (e.g. posted on enrolling/licensing it as a site. ပ
- If the service does not qualify to be billed as "Out-of-Clinic," or if the U7 modifier utilization criteria above are not met, then the "In-Clinic" rate/modifier (U6) may still be billed. 6
- modifier use as defined above. The modifier must always reflect accurate accountability to the requirements above, whereas the Place of The Place of Service code required on a progress note/claim may not always seem to intuitively align with the In-Clinic and Out-of-Clinic Service code is permitted to be generalized and is not used for auditing/accountability purposes. ന
- Claims In situations where multiple practitioners of the same U-level deliver a service (or services) for which the same procedure code and modifier(s) would be billed, but service delivery occurs at two different times, the time would need to be aggregated into one claim. If a different Place of Service code were applicable for each practitioner, only one should be selected and used on the aggregated claim. 4.
 - other natural supports, multi-disciplinary team members, etc.). Progress notes should also reflect the specific interaction that occurred during the Participation in intervention – Progress notes should reflect all the participants in the treatment and/or support intervention (individual, family, reported timeframe, and therefore, not a duplication of another note. ij.
- Signature, Printed staff name, qualifications and/or title The writer of the documentation is designated by name and credentials/qualifications and when required, degree and title. If an individual is a licensed practitioner, the printed name must be the name listed on his or her practitioner's ×. ×

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⁹ See Standards for All Behavioral Health Providers, Part II for additional information regarding credentials.

icense on all medical record documentation 10. An original signature is required. The printed name and qualifications and/or title may be recorded using a stamp or typed onto the document. Automated or electronic documentation must include a secure electronic signature11

provider is responsible for ensuring that it is clear that the additional pages are a continuation of the progress note. For example, in a 2-page note, Consistency - Documentation must follow a consistent, uniform format. Should the progress note cross multiple pages in a paper record, the page 2 must contain the name of the individual, date of service, a page number, and indication that the signature of the practitioner or paraprofessional is related to the progress note on page 1. ≥.

Diversionary and non-billable activities: × ×

- Providers may not bill for multiple services which are direct interventions with the individual during the same time period. If multiple services are determined to have been billed at the same or overlapping time period, billing for those services are subject to recoupment. Allowable exceptions include an individual receiving a service during the same time period or overlapping time period as:
- A service provided without client present as indicated with the modifier "HS"; or
- A collateral contact service as indicated by the modifier "UK"; and
- contact. This is only allowable when at least one of the services do not require that the individual be present and the progress note For example, a provider may bill Individual Counseling with the individual while, simultaneously, CM is being billed for a collateral documents such.
- employed by the same agency, and other administrative duties not explicitly allowed within the Service Guidelines are non-billable activities. appointments, observation/monitoring, tutoring, transportation, completing paperwork, communication/coordination between practitioners Non-billable activities are those activities or administrative work that do not fall within the Service Definition. For example, confirming Billing for non-billable activities is subject to recoupment. <u>.</u>
 - Billing for services that do not fall within the respective Service Definition is subject to recoupment. ပ ပဲ
- Diversionary activities are activities/time during which a therapeutic intervention tied to a goal on the IRP is not occurring. Diversionary activities which are billed are subject to recoupment.

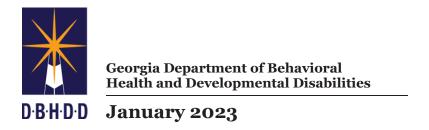
EVENT NOTES <u>ල</u>

In addition to progress notes that document the intervention(s), records must also include event notes documenting:

- Issues, situations or events occurring in the life of the individual;
- The individual's response to the issues, situations or events; <u>а</u>
- Relationships and interactions with family and friends, if applicable; ن

of it is acceptable that the initials can be used for first and middle names. The last name must be spelled out and each of these must correlate with the names on the license. This is an effort to ensure that a connection can be made between the printed/stamped name on the chart entry and a license.

¹¹ As defined in PART I POLICIES AND PROCEDURES FOR MEDICAID/PEACHCARE FOR KIDS, a Secure Electronic Signature means an electronic or digital signature, symbol, or process associated with a document which is created, transmitted, received, or stored by electronic means which (1) requires the application of a security procedure; (2) capable of verification/authentication; (3) adopted by a party with the intent to be bound or to authenticate a record; (4) signed under penalty of perjury; (5) unique to the person using it; (6) under the sole control of the person using it; and (7) linked to data in such a manner that if the data is changed the electronic signature is invalidated.



PART III

General Policies and Procedures

Provider Manual for Community Behavioral Health Providers

Fiscal Year 2023

DBHDD PolicyStat enables community providers of mental health, developmental disabilities and/or addictive diseases services to have access to all DBHDD policies that are relevant for community services. DBHDD PolicyStat can be accessed online anytime at https://gadbhdd.policystat.com/. By virtue of their contract or agreement with DBHDD, providers are required to comply with DBHDD policies relevant to their contracted services and/or according to the applicability as defined in the policy itself.

Additional information about how to utilize DBHDD PolicyStat is included in the following policy: **ACCESS TO DBHDD POLICIES FOR COMMUNITY PROVIDERS, 04-100** which is posted at https://gadbhdd.policystat.com/.



Georgia Department of Behavioral Health and Developmental Disabilities

January 2023

PART IV

Appendices

Provider Manual for Community Behavioral Health Providers

Fiscal Year 2023



Georgia Department of Behavioral Health and Developmental Disabilities

January 2023

APPENDIX A: GLOSSARY OF TERMS

Administrative Services Organization (ASO): An agency contracted by DBHDD to review provider applications, provide service authorizations, provide agency audits and data collection related to the Behavioral Health and Developmental Disabilities Provider Networks and services.

Collateral Contact: Collateral contacts are either 1) communication, on behalf of the individual, with a source of information that is knowledgeable about the individual's situation and serves to support, clarify, expound on, or corroborate information provided by the individual or 2) contacts which are not face-to-face with the individual. With appropriate releases and permissions from the individual, communication with a collateral contact may be made in person or over the telephone. Collateral contacts include, but are not limited to:

- Family members/close friends/natural supporters;
- Employers;
- School officials:
- Neighbors;
- Landlords;
- Medical professionals;
- Law Enforcement/Community Supervision Officers;
- Other agencies/community resources/treatment providers.

DC 0-5™ Manual: A diagnostic classification manual for mental health and developmental disorders of infancy and early childhood. The manual supports clinicians in the diagnosis of these disorders in young children through a systematic and multiaxial approach to diagnosis.

Diagnostic & Statistical Manual of Mental Disorders: The American Psychiatric Association's classification and diagnostic tool for behavioral health conditions. When the term DSM is referenced, it is specifically in reference to the current version of the manual.

Evidence Based Practice (EBP): A treatment or supportive approach/practice-protocol that is based upon the application of the best available research evidence for achieving desired consumer outcomes.

GCAL: Georgia Crisis and Access Line, an operational branch of the Administrative Services Organization.

ICD: International Statistical Classification of Diseases and Related Health Problems, a medical classification list by the World Health Organization (WHO).

Independently Licensed Clinician/Practitioner: An individual who by Georgia Code can practice independently without supervision. These individuals include physicians, psychologists, Licensed Clinical Social Workers, Licensed Professional Counselors, and Licensed Marriage and Family Therapists

Physician Assessment and Care: A term that is used in this manual interchangeably with Psychiatric Treatment.

Place of Service: Federally defined codes used on electronic transactions to specify the place where service(s) were rendered.

Telemedicine: The use of medical information exchanged from one site to another via electronic communications to improve a patient's health. Electronic communication means the use of interactive telecommunications equipment that includes, at a minimum, audio and video equipment permitting two-way. real time interactive communication between the patient, and the physician or practitioner at the distant site.

APPENDIX B: VALID AUTHORIZATION DIAGNOSES

The diagnoses listed here are organized into Mental Health (MH) and Substance Use (SU) categories. Services that are uniquely identified as being MH only or SU only will require a diagnosis which is aligned with that discipline (e.g. The diagnoses listed here are organized into Mental Health (MH) and Substance Use (SU) categories. Services that are uniquely identified as being MH only or SU only will require an authorization diagnosis which is within that category of condition (e.g., Alcohol Intoxication with Use Disorder [F10.229] would be an acceptable diagnosis for requesting an authorization for Ambulatory Detox [SU]).

Diagnostic Category	ICD-10 DX Code	Diagnostic Description ICD-10	BH MH	BH SU
Schizophrenia Spectrum and Other Psychotic Disorders	F06.0	Psychotic Disorder Due to Another Medical Condition with Hallucinations	Υ	N
Schizophrenia Spectrum and Other Psychotic Disorders	F06.1	Catatonia Associated with Another Mental Disorder (Catatonia Specifier)	Υ	N
Schizophrenia Spectrum and Other Psychotic Disorders	F06.1	Catatonic Disorder Due to Another Medical Condition	Υ	N
Schizophrenia Spectrum and Other Psychotic Disorders	F06.1	Unspecified Catatonia	Υ	N
Schizophrenia Spectrum and Other Psychotic Disorders	F06.1	Catatonia – other	Υ	N
Schizophrenia Spectrum and Other Psychotic Disorders	F06.2	Psychotic Disorder Due to Another Medical Condition with Delusions	Υ	N
Depressive Disorders	F06.31	Depressive Disorder Due to Another Medical Condition with Depressive Features	Υ	N
Depressive Disorders	F06.32	Depressive Disorder Due to Another Medical Condition with Major Depressive-like episode	Υ	N
Bipolar and Related Disorders	F06.33	Bipolar and Related Disorder Due to Another Medical Condition with manic features	Υ	N
Bipolar and Related Disorders	F06.33	Bipolar and Related Disorder Due to Another Medical Condition with manic or hypomanic-like episode	Υ	N
Bipolar and Related Disorders	F06.34	Bipolar and Related Disorder Due to Another Medical Condition with mixed features	Υ	N
Depressive Disorders	F06.34	Depressive Disorder Due to Another Medical Condition with Mixed Features	Υ	N
Depressive Disorders	F06.34	Mood Disorder Due to Another Medical Condition with mixed features	Υ	N
Anxiety Disorders	F06.4	Anxiety Disorder Due to Another Medical Condition	Υ	N
Obsessive-Compulsive and Related Disorders	F06.8	Obsessive-Compulsive and Related Disorder Due to Another Medical Condition	Е	N
Other Mental Disorders	F06.8	Other Specified Mental Disorder Due to Another Medical Condition	Е	N
Other Mental Disorders	F06.8	Obsessive-Compulsive and Related Disorder Due to Another Medical Condition	Е	N
Personality Disorders	F07.0	Personality Change Due to Another Medical Condition	Υ	N
Other Mental Disorders	F09	Unspecified Mental Disorder Due to Another Medical Condition	Е	N
Alcohol-Related Disorders	F10.10	Alcohol Use Disorder- Mild	N	Υ
Alcohol-Related Disorders	F10.121	Alcohol Induced Delirium, With mild use disorder	N	Υ
Alcohol-Related Disorders	F10.129	Alcohol Intoxication with Use Disorder, Mild	N	Υ
Alcohol-Related Disorders	F10.130	Alcohol abuse with withdrawal, uncomplicated	N	Υ

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Diagnostic Category	ICD-10 DX Code	Diagnostic Description ICD-10	BH MH	BH SU
Alcohol-Related Disorders	F10.131	Alcohol abuse with withdrawal delirium	N	Υ
Alcohol-Related Disorders	F10.132	Alcohol abuse with withdrawal with perceptual disturbance	N	Υ
Alcohol-Related Disorders	F10.139	Alcohol abuse with withdrawal, unspecified	N	Υ
Alcohol-Related Disorders	F10.14	Alcohol - Induced Depressive Disorder, With mild use disorder	N	Υ
Alcohol-Related Disorders	F10.14	Alcohol - Induced Bipolar and Related Disorder, With mild use disorder	N	Υ
Alcohol-Related Disorders	F10.14	Alcohol-induced Depression/Bipolar/Related Disorder, with mild use	N	Υ
Alcohol-Related Disorders	F10.159	Alcohol-Induced Psychotic Disorder, With mild use disorder	N	Υ
Alcohol-Related Disorders	F10.180	Alcohol - Induced Anxiety Disorder, With mild use disorder	N	Υ
Alcohol-Related Disorders	F10.20	Alcohol Use Disorder - Moderate	N	Υ
Alcohol-Related Disorders	F10.20	Alcohol Use Disorder - Severe	N	Υ
Alcohol-Related Disorders	F10.20	Alcohol Use Disorder - Moderate/Severe	N	Υ
Alcohol-Related Disorders	F10.221	Alcohol Intoxication Delirium, With moderate or severe use disorder	N	Υ
Alcohol-Related Disorders	F10.229	Alcohol Intoxication with Use Disorder, Moderate or Severe	N	Υ
Alcohol-Related Disorders	F10.231	Alcohol withdrawal delirium	N	Υ
Alcohol-Related Disorders	F10.232	Alcohol Withdrawal with Perceptual Disturbances	N	Υ
Alcohol-Related Disorders	F10.239	Alcohol Withdrawal without Perceptual Disturbances	N	Υ
Alcohol-Related Disorders	F10.24	Alcohol - Induced Depressive Disorder, With moderate or severe use disorder	N	Υ
Alcohol-Related Disorders	F10.24	Alcohol - Induced Bipolar and Related Disorder, With moderate or severe use disorder	N	Υ
Alcohol-Related Disorders	F10.24	Alcohol-induced Depression/Bipolar/Related Disorder, with moderate or severe use	N	Υ
Alcohol-Related Disorders	F10.259	Alcohol-Induced Psychotic Disorder, With moderate or severe use disorder	N	Υ
Alcohol-Related Disorders	F10.26	Alcohol induced major neurocognitive disorder, amnestic-confabulatory type, with moderate or severe use disorder	N	Y
Alcohol-Related Disorders	F10.27	Alcohol induced major neurocognitive disorder, Nonamnestic-confabulatory type, with moderate or severe use disorder	N	Y
Alcohol-Related Disorders	F10.280	Alcohol - Induced Anxiety Disorder, With moderate or severe use disorder	N	Υ
Alcohol-Related Disorders	F10.921	Alcohol Induced Delirium, Without use disorder	N	Υ
Alcohol-Related Disorders	F10.929	Alcohol Intoxication without Use Disorder	N	Υ
Alcohol-Related Disorders	F10.930	Alcohol use, unspecified with withdrawal, uncomplicated	N	Υ
Alcohol-Related Disorders	F10.931	Alcohol use, unspecified with withdrawal delirium	N	Υ

Diagnostic Category	ICD-10 DX Code	Diagnostic Description ICD-10	BH MH	BH SU
Alcohol-Related Disorders	F10.932	Alcohol use, unspecified with withdrawal with perceptual disturbance	N	Υ
Alcohol-Related Disorders	F10.939	Alcohol use, unspecified with withdrawal, unspecified	N	Υ
Alcohol-Related Disorders	F10.94	Alcohol - Induced Depressive Disorder, Without use disorder	N	Υ
Alcohol-Related Disorders	F10.94	Alcohol - Induced Bipolar and Related Disorder, Without use disorder	N	Υ
Alcohol-Related Disorders	F10.94	Alcohol-induced Depression/Bipolar/Related Disorder, without use	N	Υ
Alcohol-Related Disorders	F10.959	Alcohol-Induced Psychotic Disorder, Without use disorder	N	Υ
Alcohol-Related Disorders	F10.96	Alcohol -Induced major neurocognitive disorder, amnestic-confabulatory type, without use disorder	N	Υ
Alcohol-Related Disorders	F10.97	Alcohol - Induced major neurocognitive disorder, nonamnestic-confabulatory type, without use disorder	N	Υ
Alcohol-Related Disorders	F10.980	Alcohol - Induced Anxiety Disorder, Without use disorder	N	Υ
Alcohol-Related Disorders	F10.99	Unspecified Alcohol-Related Disorder	N	Υ
Opioid-Related Disorders	F11.10	Opioid Use Disorder - Mild	N	Υ
Opioid-Related Disorders	F11.13	Opioid abuse with withdrawal	N	Υ
Opioid-Related Disorders	F11.121	Opioid intoxication Delirium, With mild use disorder	N	Υ
Opioid-Related Disorders	F11.122	Opioid Intoxication with Perceptual Disturbances, with Use Disorder, Mild	N	Υ
Opioid-Related Disorders	F11.129	Opioid Intoxication without Perceptual Disturbances, with Use Disorder, Mild	N	Υ
Opioid-Related Disorders	F11.14	Opioid - Induced Depressive Disorder, With mild use disorder	N	Υ
Opioid-Related Disorders	F11.181	Opioid- Induced Sexual Dysfunction, With mild use disorder	N	Υ
Opioid-Related Disorders	F11.188	Opioid - Induced Anxiety Disorder, With mild use disorder	N	Υ
Opioid-Related Disorders	F11.20	Opioid Use Disorder - Moderate	N	Υ
Opioid-Related Disorders	F11.20	Opioid Use Disorder - Severe	N	Υ
Opioid-Related Disorders	F11.20	Opioid Use Disorder - Moderate/Severe	N	Υ
Opioid-Related Disorders	F11.221	Opioid Intoxication Delirium, With moderate or severe use disorder	N	Υ
Opioid-Related Disorders	F11.222	Opioid Intoxication with Perceptual Disturbances, with Use Disorder, Moderate or Severe	N	Υ
Opioid-Related Disorders	F11.229	Opioid Intoxication without Perceptual Disturbances, with Use Disorder, Moderate or Severe	N	Υ
Opioid-Related Disorders	F11.23	Opioid Withdrawal	N	Υ
Opioid-Related Disorders	F11.24	Opioid - Induced Depressive Disorder, With moderate or severe use disorder	N	Υ
Opioid-Related Disorders	F11.281	Opioid- Induced Sexual Dysfunction, With moderate or severe use disorder	N	Υ
Opioid-Related Disorders	F11.282	Opioid-Induced Sleep Disorder, With moderate or severe use disorder	N	Υ

Diagnostic Category	ICD-10 DX Code	Diagnostic Description ICD-10	BH MH	BH SU
Opioid-Related Disorders	F11.288	Opioid - Induced Anxiety Disorder, With moderate or severe use disorder	N	Υ
Opioid-Related Disorders	F11.921	Opioid Intoxication Delirium, Without use disorder	N	Υ
Opioid-Related Disorders	F11.921	Opioid -induced delirium	N	Υ
Opioid-Related Disorders	F11.921	Opioid Delirium	N	Υ
Opioid-Related Disorders	F11.922	Opioid Intoxication with Perceptual Disturbances, without Use Disorder	N	Υ
Opioid-Related Disorders	F11.929	Opioid Intoxication without Perceptual Disturbances, without Use Disorder	N	Υ
Opioid-Related Disorders	F11.94	Opioid - Induced Depressive Disorder, Without use disorder	N	Y
Opioid-Related Disorders	F11.981	Opioid- Induced Sexual Dysfunction, Without use disorder	N	Υ
Opioid-Related Disorders	F11.982	Opioid-Induced Sleep Disorder, Without use disorder	N	Υ
Opioid-Related Disorders	F11.988	Opioid - Induced Anxiety Disorder, Without use disorder	N	Y
Opioid-Related Disorders	F11.99	Unspecified Opioid-Related Disorder	N	Υ
Cannabis-Related Disorders	F12.10	Cannabis Use Disorder - Mild	N	Υ
Cannabis-Related Disorders	F12.121	Cannabis Intoxication Delirium, With mild use disorder	N	Υ
Cannabis-Related Disorders	F12.122	Cannabis Intoxication with Perceptual Disturbances, with Use Disorder, Mild	N	Υ
Cannabis-Related Disorders	F12.129	Cannabis Intoxication without Perceptual Disturbances, with Use Disorder, Mild	N	Υ
Cannabis-Related Disorders	F12.13	Cannabis abuse with withdrawal	N	Υ
Cannabis-Related Disorders	F12.159	Cannabis -Induced Psychotic Disorder, With mild use disorder	N	Υ
Cannabis-Related Disorders	F12.180	Cannabis - Induced Anxiety Disorder, With mild use disorder	N	Y
Cannabis-Related Disorders	F12.188	Cannabis-Induced Sleep Disorder, With mild use disorder	N	Υ
Cannabis-Related Disorders	F12.20	Cannabis Use Disorder - Moderate	N	Υ
Cannabis-Related Disorders	F12.20	Cannabis Use Disorder - Severe	N	Υ
Cannabis-Related Disorders	F12.20	Cannabis Use Disorder - Moderate/Severe	N	Υ
Cannabis-Related Disorders	F12.221	Cannabis Intoxication Delirium, With moderate or severe use disorder	N	Υ
Cannabis-Related Disorders	F12.222	Cannabis Intoxication with Perceptual Disturbances, with Use Disorder, Moderate or Severe	N	Υ
Cannabis-Related Disorders	F12.229	Cannabis Intoxication without Perceptual Disturbances, with Use Disorder, Moderate or Severe	N	Y
Cannabis-Related Disorders	F12.259	Cannabis -Induced Psychotic Disorder, With moderate or severe use disorder	N	Υ
Cannabis-Related Disorders	F12.280	Cannabis - Induced Anxiety Disorder, With moderate or severe use disorder	N	Υ
Cannabis-Related Disorders	F12.288	Cannabis Withdrawal	N	Υ
Cannabis-Related Disorders	F12.921	Cannabis Intoxication Delirium, Without use disorder	N	Υ
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F12.922

Cannabis Intoxication with Perceptual Disturbances,

without Use Disorder

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Cannabis-Related Disorders

Diagnostic Category	ICD-10 DX Code	Diagnostic Description ICD-10	BH MH	BH SU
Cannabis-Related Disorders	F12.929	Cannabis Intoxication without Perceptual Disturbances, without Use Disorder	N	Υ
Cannabis-Related Disorders	F12.959	Cannabis -Induced Psychotic Disorder, Without use disorder	N	Υ
Cannabis-Related Disorders	F12.980	Cannabis - Induced Anxiety Disorder, Without use disorder	N	Υ
Cannabis-Related Disorders	F12.988	Cannabis-Induced Sleep Disorder, Without use disorder	N	Υ
Cannabis-Related Disorders	F12.99	Unspecified Cannabis-Related Disorder	N	Υ
Sedative-, Hypnotic-, or Anxiolytic- Related Disorders	F13.10	Sedative, Hypnotic, or Anxiolytic Use Disorder – Mild	N	Υ
Sedative-, Hypnotic-, or Anxiolytic- Related Disorders	F13.121	Sedative, hypnotic, or anxiolytic Intoxication Delirium, With mild use disorder	N	Υ
Sedative-, Hypnotic-, or Anxiolytic- Related Disorders	F13.129	Sedative, Hypnotic, or Anxiolytic Intoxication with Use Disorder, Mild	N	Υ
Sedative-, Hypnotic-, or Anxiolytic- Related Disorders	F13.130	Sedative, hypnotic or anxiolytic abuse with withdrawal, uncomplicated	N	Υ
Sedative-, Hypnotic-, or Anxiolytic- Related Disorders	F13.131	Sedative, hypnotic or anxiolytic abuse with withdrawal delirium	N	Υ
Sedative-, Hypnotic-, or Anxiolytic- Related Disorders	F13.132	Sedative, hypnotic or anxiolytic abuse with withdrawal with perceptual disturbance	N	Υ
Sedative-, Hypnotic-, or Anxiolytic- Related Disorders	F13.139	Sedative, hypnotic or anxiolytic abuse with withdrawal, unspecified	N	Υ
Sedative-, Hypnotic-, or Anxiolytic- Related Disorders	F13.14	Sedative, Hypnotic, or Anxiolytic - Induced Bipolar and Related Disorder, With mild use disorder	N	Υ
Sedative-, Hypnotic-, or Anxiolytic- Related Disorders	F13.14	Sedative, hypnotic, or anxiolytic - Induced Depressive Disorder, With mild use disorder	N	Υ
Sedative-, Hypnotic-, or Anxiolytic- Related Disorders	F13.14	Sedative, Hypnotic, or Anxiolytic - Induced Depressive/Bipolar/Related Disorder, With mild use disorder	N	Y
Sedative-, Hypnotic-, or Anxiolytic- Related Disorders	F13.159	Sedative, hypnotic, or anxiolytic Induced Psychotic Disorder, With mild use disorder	N	Υ
Sedative-, Hypnotic-, or Anxiolytic- Related Disorders	F13.180	Sedative, hypnotic, or anxiolytic - Induced Anxiety Disorder, With mild use disorder	N	Υ
Sedative-, Hypnotic-, or Anxiolytic- Related Disorders	F13.181	Sedative, Hypnotic, or Anxiolytic- Induced Sexual Dysfunction, With mild use disorder	N	Υ
Sedative-, Hypnotic-, or Anxiolytic- Related Disorders	F13.20	Sedative, Hypnotic, or Anxiolytic Use Disorder – Moderate	N	Υ
Sedative-, Hypnotic-, or Anxiolytic- Related Disorders	F13.20	Sedative, Hypnotic, or Anxiolytic Use Disorder – Severe	N	Υ
Sedative-, Hypnotic-, or Anxiolytic- Related Disorders	F13.20	Sedative, Hypnotic, or Anxiolytic Use Disorder - Moderate - Severe	N	Υ
Sedative-, Hypnotic-, or Anxiolytic- Related Disorders	F13.221	Sedative, hypnotic, or anxiolytic Intoxication Delirium, With moderate or severe use disorder	N	Υ
Sedative-, Hypnotic-, or Anxiolytic- Related Disorders	F13.229	Sedative, Hypnotic, or Anxiolytic Intoxication with Use Disorder, Moderate or Severe	N	Υ
Sedative-, Hypnotic-, or Anxiolytic- Related Disorders	F13.231	Sedative, hypnotic, or anxiolytic withdrawal delirium	N	Υ
Sedative-, Hypnotic-, or Anxiolytic- Related Disorders	F13.232	Sedative, Hypnotic, or Anxiolytic Withdrawal with Perceptual Disturbances	N	Υ

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Diagnostic Category	ICD-10 DX Code	Diagnostic Description ICD-10	BH MH	BH SU
Sedative-, Hypnotic-, or Anxiolytic- Related Disorders	F13.239	Sedative, Hypnotic, or Anxiolytic Withdrawal without Perceptual Disturbances	N	Υ
Sedative-, Hypnotic-, or Anxiolytic- Related Disorders	F13.24	Sedative, Hypnotic, or Anxiolytic - Induced Bipolar and Related Disorder, With moderate or severe use disorder	N	Υ
Sedative-, Hypnotic-, or Anxiolytic- Related Disorders	F13.24	Sedative, hypnotic, or anxiolytic - Induced Depressive Disorder, With moderate or severe use disorder	N	Υ
Sedative-, Hypnotic-, or Anxiolytic- Related Disorders	F13.24	Sedative, Hypnotic, or Anxiolytic - Induced Depressive/Bipolar/Related Disorder, With moderate or severe use	N	Y
Sedative-, Hypnotic-, or Anxiolytic- Related Disorders	F13.259	Sedative, hypnotic, or anxiolytic Induced Psychotic Disorder, With moderate or severe use disorder	N	Υ
Sedative-, Hypnotic-, or Anxiolytic- Related Disorders	F13.27	Sedative, hypnotic, or anxiolytic -induced major neurocognitive disorder, With moderate or severe use disorder	N	Υ
Sedative-, Hypnotic-, or Anxiolytic- Related Disorders	F13.280	Sedative, hypnotic, or anxiolytic - Induced Anxiety Disorder, With moderate or severe use disorder	N	Υ
Sedative-, Hypnotic-, or Anxiolytic- Related Disorders	F13.281	Sedative, Hypnotic, or Anxiolytic- Induced Sexual Dysfunction, With moderate or severe use disorder	N	Υ
Sedative-, Hypnotic-, or Anxiolytic- Related Disorders	F13.282	Sedative, hypnotic, or Anxiolytic-Induced Sleep Disorder, With moderate or severe use disorder	N	Υ
Sedative-, Hypnotic-, or Anxiolytic- Related Disorders	F13.288	Sedative, hypnotic, or anxiolytic-induced mild neurocognitive disorder, With moderate or severe use disorder	N	Υ
Sedative-, Hypnotic-, or Anxiolytic- Related Disorders	F13.921	Sedative, hypnotic, or anxiolytic Intoxication Delirium, Without use disorder	N	Υ
Sedative-, Hypnotic-, or Anxiolytic- Related Disorders	F13.921	Sedative, hypnotic, or anxiolytic -induced delirium	N	Υ
Sedative-, Hypnotic-, or Anxiolytic- Related Disorders	F13.921	Sedative, hypnotic, or anxiolytic delirium	N	Υ
Sedative-, Hypnotic-, or Anxiolytic- Related Disorders	F13.929	Sedative, Hypnotic, or Anxiolytic Intoxication without Use Disorder	N	Υ
Sedative-, Hypnotic-, or Anxiolytic- Related Disorders	F13.94	Sedative, Hypnotic, or Anxiolytic - Induced Bipolar and Related Disorder, Without use disorder	N	Υ
Sedative-, Hypnotic-, or Anxiolytic- Related Disorders	F13.94	Sedative, hypnotic, or anxiolytic - Induced Depressive Disorder, Without use disorder	N	Υ
Sedative-, Hypnotic-, or Anxiolytic- Related Disorders	F13.94	Sedative, Hypnotic, or Anxiolytic - Induced Depressive/Bipolar/ Related Disorder, Without use disorder	N	Υ
Sedative-, Hypnotic-, or Anxiolytic- Related Disorders	F13.959	Sedative, hypnotic, or anxiolytic Induced Psychotic Disorder, Without use disorder	N	Υ
Sedative-, Hypnotic-, or Anxiolytic- Related Disorders	F13.97	Sedative, hypnotic, or anxiolytic-induced major neurocognitive disorder, Without use disorder	N	Υ
Sedative-, Hypnotic-, or Anxiolytic- Related Disorders	F13.980	Sedative, hypnotic, or anxiolytic - Induced Anxiety Disorder, Without use disorder	N	Υ
Sedative-, Hypnotic-, or Anxiolytic- Related Disorders	F13.981	Sedative, Hypnotic, or Anxiolytic- Induced Sexual Dysfunction, Without use disorder	N	Υ
Sedative-, Hypnotic-, or Anxiolytic- Related Disorders	F13.988	Sedative, hypnotic, or anxiolytic-induced mild neurocognitive disorder, Without use disorder	N	Υ

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Diagnostic Category	ICD-10 DX Code	Diagnostic Description ICD-10	BH MH	BH SU
Sedative-, Hypnotic-, or Anxiolytic- Related Disorders	F13.99	Unspecified Sedative-, Hypnotic-, or Anxiolytic- Related Disorder	N	Υ
Stimulant-Related Disorders	F14.10	Stimulant Use Disorder - Cocaine - Mild	N	Υ
Stimulant Related Disorders	F14.121	Cocaine intoxication delirium, With mild use disorder	N	Υ
Stimulant-Related Disorders	F14.122	Stimulant Intoxication - Cocaine, With Perceptual Disturbances - With Use Disorder, Mild	N	Υ
Stimulant-Related Disorders	F14.129	Stimulant Intoxication - Cocaine, Without Perceptual Disturbances - With Use Disorder, Mild	N	Υ
Stimulant-Related Disorders	F14.13	Cocaine abuse, unspecified with withdrawal	N	Υ
Stimulant Related Disorders	F14.14	Cocaine - Induced Bipolar and Related Disorder, With mild use disorder	N	Υ
Stimulant Related Disorders	F14.14	Cocaine - Induced Depressive Disorder, With mild use disorder	N	Υ
Stimulant Related Disorders	F14.14	Cocaine - Induced Depressive/Bipolar/Related Disorder, With mild use disorder	N	Υ
Stimulant Related Disorders	F14.159	Cocaine-Induced Psychotic Disorder, With mild use disorder	N	Υ
Stimulant Related Disorders	F14.180	Cocaine - Induced Anxiety Disorder, With mild use disorder	N	Υ
Stimulant Related Disorders	F14.181	Cocaine - Induced Sexual Dysfunction, With mild use disorder	N	Υ
Stimulant Related Disorders	F14.188	Cocaine - Induced Obsessive-Compulsive and Related Disorder, With mild use disorder	N	Υ
Stimulant-Related Disorders	F14.20	Stimulant Use Disorder - Cocaine - Moderate	N	Υ
Stimulant-Related Disorders	F14.20	Stimulant Use Disorder - Cocaine - Severe	N	Υ
Stimulant-Related Disorders	F14.20	Stimulant Use Disorder - Cocaine - Moderate/Severe	N	Υ
Stimulant Related Disorders	F14.221	Cocaine Intoxication delirium, With moderate or severe use disorder	N	Υ
Stimulant-Related Disorders	F14.222	Stimulant Intoxication - Cocaine, With Perceptual Disturbances - With Use Disorder, Moderate or Severe	N	Y
Stimulant-Related Disorders	F14.229	Stimulant Intoxication - Cocaine, Without Perceptual Disturbances - With Use Disorder, Moderate or Severe	N	Υ
Stimulant-Related Disorders	F14.23	Stimulant Withdrawal - Cocaine	N	Υ
Stimulant Related Disorders	F14.24	Cocaine - Induced Bipolar and Related Disorder, With moderate or severe use disorder	N	Υ
Stimulant Related Disorders	F14.24	Cocaine - Induced Depressive Disorder, With moderate or severe use disorder	N	Υ
Stimulant Related Disorders	F14.24	Cocaine - Induced Depressive/Bipolar/Related Disorder, With moderate or severe use	N	Υ
Stimulant Related Disorders	F14.259	Cocaine-Induced Psychotic Disorder, With moderate or severe use disorder	N	Υ
Stimulant Related Disorders	F14.280	Cocaine - Induced Anxiety Disorder, With moderate or severe use disorder	N	Υ
Stimulant Related Disorders	F14.281	Cocaine - Induced Sexual Dysfunction, With moderate or severe use disorder	N	Υ

Diagnostic Category	ICD-10 DX Code	Diagnostic Description ICD-10	BH MH	BH SU
Stimulant Related Disorders	F14.282	Cocaine-Induced Sleep Disorder, With moderate or severe use disorder	N	Υ
Stimulant Related Disorders	F14.288	Cocaine - Induced Obsessive-Compulsive and Related Disorder, With moderate or severe use disorder	N	Υ
Stimulant Related Disorders	F14.921	Cocaine Intoxication Delirium, Without use disorder	N	Υ
Stimulant-Related Disorders	F14.922	Stimulant Intoxication - Cocaine, With Perceptual Disturbances - Without Use Disorder	N	Y
Stimulant-Related Disorders	F14.929	Stimulant Intoxication - Cocaine, Without Perceptual Disturbances - Without Use Disorder	N	Υ
Stimulant-Related Disorders	F14.93	Cocaine use, unspecified with withdrawal	N	Υ
Stimulant Related Disorders	F14.94	Cocaine - Induced Bipolar and Related Disorder, Without use disorder	N	Υ
Stimulant Related Disorders	F14.94	Cocaine - Induced Depressive Disorder, Without use disorder	N	Υ
Stimulant Related Disorders	F14.94	Cocaine - Induced Depressive/Bipolar/Related Disorder, Without use	N	Υ
Stimulant Related Disorders	F14.959	Cocaine-Induced Psychotic Disorder, Without use disorder	N	Y
Stimulant Related Disorders	F14.980	Cocaine - Induced Anxiety Disorder, Without use disorder	N	Υ
Stimulant Related Disorders	F14.981	Cocaine - Induced Sexual Dysfunction, Without use disorder	N	Υ
Stimulant Related Disorders	F14.988	Cocaine - Induced Obsessive-Compulsive and Related Disorder, Without use disorder	N	Υ
Stimulant-Related Disorders	F14.99	Unspecified Stimulant-Related Disorder - Cocaine	N	Υ
Stimulant-Related Disorders	F15.10	Stimulant Use Disorder - Amphetamine-type Substance - Mild	N	Υ
Stimulant-Related Disorders	F15.10	Stimulant Use Disorder - Other or Unspecified Stimulant – Mild	N	Υ
Stimulant-Related Disorders	F15.10	Stimulant Use Disorder - other, mild	N	Υ
Stimulant Related Disorders	F15.121	Amphetamine (or other stimulant) Intoxication Delirium, With mild use disorder	N	Υ
Stimulant-Related Disorders	F15.122	Stimulant Intoxication - Amphetamine or other stimulant, With Perceptual Disturbances - With Use Disorder, Mild	N	Y
Stimulant-Related Disorders	F15.129	Stimulant Intoxication - Amphetamine or other stimulant, Without Perceptual Disturbances - With Use Disorder, Mild	N	Y
Stimulant-Related Disorders	F15.13	Other stimulant abuse with withdrawal	N	Υ
Stimulant Related Disorders	F15.14	Amphetamine (or other stimulant) - Induced Bipolar and Related Disorder, With mild use disorder	N	Y
Stimulant Related Disorders	F15.14	Amphetamine (or other stimulant) - Induced Depressive Disorder, With mild use disorder	N	Υ
Stimulant Related Disorders	F15.14	Amphetamine (or other stimulant) - Induced Depressive/Bipolar/Related Disorder, With mild use disorder	N	Y

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Diagnostic Category	ICD-10 DX Code	Diagnostic Description ICD-10	BH MH	BH SU
Stimulant Related Disorders	F15.159	Amphetamine (or other stimulant) Induced Psychotic Disorder, With mild use disorder	N	Υ
Stimulant Related Disorders	F15.180	Caffeine - Induced Anxiety Disorder, With mild use disorder	N	Υ
Stimulant Related Disorders	F15.180	Amphetamine (or other stimulant) - Induced Anxiety Disorder, With mild use disorder	N	Υ
Stimulant Related Disorders	F15.181	Amphetamine (or other stimulant) - Induced Sexual Dysfunction, With mild use disorder	N	Υ
Stimulant Related Disorders	F15.188	Amphetamine (or other stimulant) - Induced Obsessive-Compulsive and Related Disorder, With mild use disorder	N	Y
Stimulant-Related Disorders	F15.20	Stimulant Use Disorder - Amphetamine-type Substance - Moderate	N	Υ
Stimulant-Related Disorders	F15.20	Stimulant Use Disorder - Amphetamine-type Substance - Severe	N	Υ
Stimulant-Related Disorders	F15.20	Stimulant Use Disorder - Other or Unspecified Stimulant - Moderate	N	Υ
Stimulant-Related Disorders	F15.20	Stimulant Use Disorder - Other or Unspecified Stimulant - Severe	N	Υ
Stimulant-Related Disorders	F15.20	Stimulant Use Disorder - other, moderate - severe	N	Υ
Stimulant Related Disorders	F15.221	Amphetamine (or other stimulant) intoxication delirium, With moderate or severe use disorder.	N	Y
Stimulant-Related Disorders	F15.222	Stimulant Intoxication - Amphetamine or other stimulant, With Perceptual Disturbances - With Use Disorder, Moderate or Severe	N	Y
Stimulant-Related Disorders	F15.229	Stimulant Intoxication - Amphetamine or other stimulant, Without Perceptual Disturbances - With Use Disorder, Moderate or Severe	N	Y
Stimulant-Related Disorders	F15.23	Stimulant Withdrawal - Amphetamine or Other Stimulant	N	Υ
Stimulant Related Disorders	F15.24	Amphetamine (or other stimulant) - Induced Depressive Disorder, With moderate or severe use disorder	N	Y
Stimulant Related Disorders	F15.24	Amphetamine (or other stimulant)-Induced Bipolar and Related Disorder, With moderate or severe use disorder	N	Y
Stimulant Related Disorders	F15.24	Amphetamine (or other stimulant)-Induced Depressive/Bipolar/Related Disorder, With moderate or severe use disorder	N	Y
Stimulant Related Disorders	F15.259	Amphetamine (or other stimulant) Induced Psychotic Disorder, With moderate or severe use disorder	N	Υ
Stimulant Related Disorders	F15.280	Caffeine - Induced Anxiety Disorder, With moderate or severe use disorder	N	Y
Stimulant Related Disorders	F15.280	Amphetamine (or other stimulant) - Induced Anxiety Disorder, With moderate or severe use disorder	N	Υ
Stimulant Related Disorders	F15.281	Amphetamine (or other stimulant) - Induced Sexual Dysfunction, With moderate or severe use disorder	N	Υ

Diagnostic Category	ICD-10 DX Code	Diagnostic Description ICD-10	BH MH	BH SU
Stimulant Related Disorders	F15.282	Caffeine-Induced Sleep Disorder, With moderate or severe use disorder	N	Υ
Stimulant Related Disorders	F15.282	Amphetamine (or other stimulant)-Induced Sleep Disorder, With moderate or severe use disorder	N	Υ
Stimulant Related Disorders	F15.288	Amphetamine (or other stimulant) - Induced Obsessive-Compulsive and Related Disorder, With moderate or severe use disorder	N	Υ
Stimulant Related Disorders	F15.921	Amphetamine (or other stimulant) Intoxication Delirium, Without use disorder	N	Υ
Stimulant Related Disorders	F15.921	Amphetamine-type (or other stimulant) -induced delirium	N	Υ
Stimulant Related Disorders	F15.921	Amphetamine or Amphetamine-type delirium	N	Υ
Stimulant-Related Disorders	F15.922	Stimulant Intoxication - Amphetamine or other stimulant, With Perceptual Disturbances - Without Use Disorder	N	Υ
Stimulant-Related Disorders	F15.929	Stimulant Intoxication - Amphetamine or other stimulant, Without Perceptual Disturbances - Without Use Disorder	N	Υ
Combined Other Substance Disorders	F15.929	Caffeine Intoxication	N	Υ
Combined Other Substance Disorders	F15.929	Stimulant Use Intoxication	N	Υ
Stimulant Related Disorders	F15.94	Amphetamine (or other stimulant) - Induced Bipolar and Related Disorder, Without use disorder	N	Υ
Stimulant Related Disorders	F15.94	Amphetamine (or other stimulant) - Induced Depressive Disorder, Without use disorder	N	Υ
Stimulant Related Disorders	F15.94	Amphetamine (or other stimulant) - Induced Depressive/Bipolar/Related Disorder, Without use disorder	N	Y
Stimulant Related Disorders	F15.959	Amphetamine (or other stimulant) Induced Psychotic Disorder, Without use disorder	N	Υ
Stimulant Related Disorders	F15.980	Caffeine - Induced Anxiety Disorder, Without use disorder	N	Υ
Stimulant Related Disorders	F15.980	Amphetamine (or other stimulant) - Induced Anxiety Disorder, Without use disorder	N	Υ
Stimulant Related Disorders	F15.981	Amphetamine (or other stimulant) - Induced Sexual Dysfunction, Without use disorder	N	Υ
Stimulant Related Disorders	F15.988	Amphetamine (or other stimulant) - Induced Obsessive-Compulsive and Related Disorder, Without use disorder	N	Υ
Combined Other Substance Disorders	F15.99	Unspecified Caffeine-Related Disorder	N	Υ
Stimulant-Related Disorders	F15.99	Unspecified Stimulant-Related Disorder - Amphetamine or Other Stimulant	N	Υ
Stimulant-Related Disorders	F15.99	Unspecified Stimulant-Related Disorder	N	Υ
Hallucinogen-Related Disorders	F16.10	Other Hallucinogen Use Disorder - Mild	N	Υ
Hallucinogen-Related Disorders	F16.10	Other Hallucinogen Use Disorder - Mild	N	Υ
Hallucinogen-Related Disorders	F16.121	Other hallucinogen intoxication Delirium, With mild use disorder	N	Υ

Diagnostic Category	ICD-10 DX Code	Diagnostic Description ICD-10	BH MH	BH SU
Hallucinogen-Related Disorders	F16.121	Phencyclidine Intoxication Delirium, With mild use disorder	N	Υ
Hallucinogen-Related Disorders	F16.121	Phencyclidine/Other Hallucinogen Intoxication Delirium, With mild use disorder	N	Υ
Hallucinogen-Related Disorders	F16.129	Other Hallucinogen Intoxication with Use Disorder, Mild	N	Υ
Hallucinogen-Related Disorders	F16.129	Phencyclidine Intoxication with Use Disorder, Mild	N	Υ
Hallucinogen-Related Disorders	F16.129	Hallucinogen Intoxication - other, mild	N	Υ
Hallucinogen-Related Disorders	F16.14	Other Hallucinogen - Induced Bipolar and Related Disorder, With mild use disorder	N	Υ
Hallucinogen-Related Disorders	F16.14	Phencyclidine - Induced Bipolar and Related Disorder, With mild use disorder	N	Υ
Hallucinogen-Related Disorders	F16.14	Other hallucinogen - Induced Depressive Disorder, With mild use disorder	N	Υ
Hallucinogen-Related Disorders	F16.14	Phencyclidine - Induced Depressive Disorder, With mild use disorder	N	Υ
Hallucinogen-Related Disorders	F16.14	Phencyclidine/ Other Hallucinogen - Induced Depressive Disorder, With mild use disorder	N	Υ
Hallucinogen-Related Disorders	F16.159	Other Hallucinogen-Induced Psychotic Disorder, With mild use disorder	N	Υ
Hallucinogen-Related Disorders	F16.159	Phencyclidine-Induced Psychotic Disorder, With mild use disorder	N	Υ
Hallucinogen-Related Disorders	F16.159	Phencyclidine/Other Hallucinogen -Induced Psychotic Disorder, With mild use disorder	N	Υ
Hallucinogen-Related Disorders	F16.180	Other hallucinogen - Induced Anxiety Disorder, With mild use disorder	N	Υ
Hallucinogen-Related Disorders	F16.180	Phencyclidine - Induced Anxiety Disorder, With mild use disorder	N	Υ
Hallucinogen-Related Disorders	F16.180	Phencyclidine/Other Hallucinogen - Induced Anxiety Disorder, With mild use disorder	N	Υ
Hallucinogen-Related Disorders	F16.20	Other Hallucinogen Use Disorder - Moderate	N	Υ
Hallucinogen-Related Disorders	F16.20	Other Hallucinogen Use Disorder - Severe	N	Υ
Hallucinogen-Related Disorders	F16.20	Phencyclidine Use Disorder - Moderate	N	Υ
Hallucinogen-Related Disorders	F16.20	Phencyclidine Use Disorder - Severe	N	Υ
Hallucinogen-Related Disorders	F16.20	Hallucinogen Use Disorder, other, Moderate - Severe	N	Υ
Hallucinogen-Related Disorders	F16.221	Other hallucinogen Intoxication Delirium, With moderate or severe use disorder	N	Υ
Hallucinogen-Related Disorders	F16.221	Phencyclidine Intoxication Delirium, With moderate or severe use disorder	N	Υ
Hallucinogen-Related Disorders	F16.221	Phencyclidine/Other Hallucinogen Intoxication Delirium, With moderate or severe use disorder	N	Υ
Hallucinogen-Related Disorders	F16.229	Other Hallucinogen Intoxication with Use Disorder, Moderate or Severe	N	Υ
Hallucinogen-Related Disorders	F16.229	Phencyclidine Intoxication with Use Disorder, Moderate or Severe	N	Υ
Hallucinogen-Related Disorders	F16.229	Hallucinogen Intoxication - other, moderate - severe	N	Υ
Hallucinogen-Related Disorders	F16.24	Other Hallucinogen - Induced Bipolar and Related Disorder, With moderate or severe use disorder	N	Y

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Hallucinogen-Related Disorders	F16.24	Phencyclidine - Induced Bipolar and Related Disorder, With moderate or severe use disorder	N	Υ
Hallucinogen-Related Disorders	F16.24	Other hallucinogen - Induced Depressive Disorder, With moderate or severe use disorder	N	Υ
Hallucinogen-Related Disorders	F16.24	Phencyclidine - Induced Depressive Disorder, With moderate or severe use disorder	N	Υ
Hallucinogen-Related Disorders	F16.24	Phencyclidine/other Hallucinogen - Induced Depressive Disorder, With moderate or severe use disorder	N	Υ
Hallucinogen-Related Disorders	F16.259	Other Hallucinogen-Induced Psychotic Disorder, With moderate or severe use disorder	N	Υ
Hallucinogen-Related Disorders	F16.259	Phencyclidine-Induced Psychotic Disorder, With moderate or severe use disorder	N	Υ
Hallucinogen-Related Disorders	F16.259	Phencyclidine/Other Hallucinogen-Induced Psychotic Disorder, With moderate or severe use disorder	N	Υ
Hallucinogen-Related Disorders	F16.280	Other hallucinogen - Induced Anxiety Disorder, With moderate or severe use disorder	N	Υ
Hallucinogen-Related Disorders	F16.280	Phencyclidine - Induced Anxiety Disorder, With moderate or severe use disorder	N	Υ
Hallucinogen-Related Disorders	F16.280	Phencyclidine/Other Hallucinogen - Induced Anxiety Disorder, With moderate or severe use disorder	N	Υ
Hallucinogen Related Disorders	F16.921	Phencyclidine/Other Hallucinogen Intoxication Delirium, Without use disorder	N	Υ
Hallucinogen-Related Disorders	F16.921	Other hallucinogen Intoxication Delirium, Without use disorder	N	Υ
Hallucinogen-Related Disorders	F16.921	Phencyclidine Intoxication Delirium, Without use disorder	N	Υ
Hallucinogen-Related Disorders	F16.929	Other Hallucinogen Intoxication without Use Disorder	N	Υ
Hallucinogen-Related Disorders	F16.929	Phencyclidine Intoxication without Use Disorder	N	Υ
Hallucinogen-Related Disorders	F16.929	Hallucinogen Intoxication - other, without Use Disorder	N	Υ
Hallucinogen Related Disorders	F16.94	Phencyclidine - Induced Depressive Disorder, Without use disorder	N	Υ
Hallucinogen Related Disorders	F16.94	Phencyclidine/Other Hallucinogen - Induced Depressive Disorder, Without use disorder	N	Υ
Hallucinogen-Related Disorders	F16.94	Other Hallucinogen - Induced Bipolar and Related Disorder, Without use disorder	N	Υ
Hallucinogen-Related Disorders	F16.94	Phencyclidine - Induced Bipolar and Related Disorder, Without use disorder	N	Υ
Hallucinogen-Related Disorders	F16.94	Other hallucinogen - Induced Depressive Disorder, Without use disorder	N	Υ
Hallucinogen Related Disorders	F16.959	Other Hallucinogen-Induced Psychotic Disorder, Without use disorder	N	Υ
Hallucinogen Related Disorders	F16.959	Phencyclidine-Induced Psychotic Disorder, Without use disorder	N	Υ
Hallucinogen Related Disorders	F16.959	Phencyclidine/Other Hallucinogen -Induced Psychotic Disorder, Without use disorder	N	Υ

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Hallucinogen Related Disorders	F16.980	Other hallucinogen - Induced Anxiety Disorder, Without use disorder	N	Υ
Hallucinogen Related Disorders	F16.980	Phencyclidine - Induced Anxiety Disorder, Without use disorder	N	Υ
Hallucinogen Related Disorders	F16.980	Phencyclidine/Other Hallucinogen - Induced Anxiety Disorder, Without use disorder	N	Υ
Hallucinogen-Related Disorders	F16.983	Hallucinogen Persisting Perception Disorder	N	Υ
Hallucinogen-Related Disorders	F16.99	Unspecified Hallucinogen-Related Disorder	N	Υ
Hallucinogen-Related Disorders	F16.99	Unspecified Phencyclidine-Related Disorder	N	Υ
Hallucinogen-Related Disorders	F16.99	Unspecified Hallucinogen-Other	N	Υ
Substance-Related Disorders	F17.208	Tobacco-Induced Sleep Disorder, With moderate or severe use disorder	N	N
Combined Other Substance Disorders	F17.209	Unspecified Tobacco-Related Disorder	N	N
Inhalant Related Disorders	F18.121	Inhalant Intoxication Delirium, With mild use disorder	N	Υ
Inhalant-Related Disorders	F18.129	Inhalant Intoxication with Use Disorder, Mild	N	Υ
Inhalant Related Disorders	F18.14	Inhalant - Induced Depressive Disorder, With mild use disorder	N	Υ
Inhalant Related Disorders	F18.159	Inhalant-Induced Psychotic Disorder, With mild use disorder	N	Y
Inhalant Related Disorders	F18.17	Inhalant - Induced major neurocognitive disorder, With mild use disorder	N	Υ
Inhalant Related Disorders	F18.180	Inhalant - Induced Anxiety Disorder, With mild use disorder	N	Υ
Inhalant Related Disorders	F18.188	Inhalant - Induced Mild Neurocognitive Disorder, With mild use disorder	N	Y
Inhalant-Related Disorders	F18.20	Inhalant Use Disorder - Moderate	N	Υ
Inhalant-Related Disorders	F18.20	Inhalant Use Disorder - Severe	N	Υ
Inhalant-Related Disorders	F18.20	Inhalant Use Disorder - Moderate/Severe	N	Υ
Inhalant Related Disorders	F18.221	Inhalant Intoxication Delirium, With moderate or severe use disorder	N	Υ
Inhalant-Related Disorders	F18.229	Inhalant Intoxication with Use Disorder, Moderate or Severe	N	Υ
Inhalant Related Disorders	F18.24	Inhalant - Induced Depressive Disorder, With moderate or severe use disorder	N	Υ
Inhalant Related Disorders	F18.259	Inhalant-Induced Psychotic Disorder, With moderate or severe use disorder	N	Y
Inhalant Related Disorders	F18.27	Inhalant - Induced major neurocognitive disorder, With moderate or severe use disorder	N	Υ
Inhalant Related Disorders	F18.280	Inhalant - Induced Anxiety Disorder, With moderate or severe use disorder	N	Y
Inhalant Related Disorders	F18.288	Inhalant - Induced mild neurocognitive disorder, With moderate or severe use disorder	N	Y
Inhalant Related Disorders	F18.921	Inhalant Intoxication Delirium, Without use disorder	N	Υ
Inhalant-Related Disorders	F18.929	Inhalant Intoxication without Use Disorder	N	Υ
Inhalant Related Disorders	F18.94	Inhalant - Induced Depressive Disorder, Without use disorder	N	Υ

Diagnostic Category	ICD-10 DX Code	Diagnostic Description ICD-10	BH MH	BH SU
Inhalant Related Disorders	F18.959	Inhalant-Induced Psychotic Disorder, Without use disorder	N	Υ
Inhalant Related Disorders	F18.97	Inhalant -Induced major neurocognitive disorder, Without use disorder	N	Υ
Inhalant Related Disorders	F18.980	Inhalant - Induced Anxiety Disorder, Without use disorder	N	Υ
Inhalant Related Disorders	F18.988	Inhalant -Induced mild neurocognitive disorder, Without use disorder	N	Υ
Inhalant-Related Disorders	F18.99	Unspecified Inhalant-Related Disorder	N	Υ
Combined Other Substance Disorders	F19.10	Other (or Unknown) Substance Use Disorder - Mild	N	Υ
Combined Other Substance Disorders	F19.121	Other (or unknown) substance Intoxication Delirium, With mild use disorder	N	Υ
Combined Other Substance Disorders	F19.129	Other (or Unknown) Substance Intoxication - With Use Disorder, Mild	N	Υ
Combined Other Substance Disorders	F19.131	Other psychoactive substance abuse with withdrawal delirium	N	Υ
Combined Other Substance Disorders	F19.132	Other psychoactive substance abuse with withdrawal with perceptual disturbance	N	Υ
Combined Other Substance Disorders	F19.139	Other psychoactive substance abuse with withdrawal, unspecified	N	Υ
Combined Other Substance Disorders	F19.14	Other (or unknown) substance - Induced Bipolar and Related Disorder, With mild use disorder	N	Υ
Combined Other Substance Disorders	F19.14	Other (or unknown) substance - Induced Depressive Disorder, With mild use disorder	N	Υ
Combined Other Substance Disorders	F19.14	Other (or unknown) substance - Induced Depressive/Bipolar/Related Disorder, With mild use disorder	N	Υ
Combined Other Substance Disorders	F19.159	Other (or unknown) substance Induced Psychotic Disorder, With mild use disorder	N	Υ
Combined Other Substance Disorders	F19.17	Other (or unknown) substance induced major neurocognitive disorder, With mild use disorder	N	Υ
Combined Other Substance Disorders	F19.180	Other (or unknown) substance - Induced Anxiety Disorder, With mild use disorder	N	Υ
Combined Other Substance Disorders	F19.181	Other (Or Unknown) Substance Induced Sexual Dysfunction, With mild use disorder	N	Υ
Combined Other Substance Disorders	F19.188	Other (or unknown) substance - induced mild neurocognitive disorder, With mild use disorder	N	Υ
Combined Other Substance Disorders	F19.188	Other (or unknown) substance- Induced Obsessive- Compulsive and Related Disorder, With mild use disorder	N	Υ
Combined Other Substance Disorders	F19.188	Other (or unknown) substance-Induced mild neurocognitive/Obsessive-Compulsive/Related Disorder, With mild use disorder	N	Υ
Combined Other Substance Disorders	F19.20	Other (or Unknown) Substance Use Disorder - Moderate	N	Υ
Combined Other Substance Disorders	F19.20	Other (or Unknown) Substance Use Disorder - Severe	N	Υ

Diagnostic Category	ICD-10 DX Code	Diagnostic Description ICD-10	BH MH	BH SU
Combined Other Substance Disorders	F19.20	Substance Use Disorder, Other (or Unknown) - Moderate - Severe	N	Υ
Combined Other Substance Disorders	F19.221	Other (or unknown) substance Induced Delirium, With moderate or severe use disorder	N	Υ
Combined Other Substance Disorders	F19.229	Other (or Unknown) Substance Intoxication - With Use Disorder, Moderate or Severe	N	Υ
Combined Other Substance Disorders	F19.231	Other (or unknown) substance withdrawal delirium	N	Υ
Combined Other Substance Disorders	F19.239	Other (or Unknown) Substance Withdrawal	N	Υ
Combined Other Substance Disorders	F19.24	Other (or unknown) substance - Induced Bipolar and Related Disorder, With moderate or severe use disorder	N	Y
Combined Other Substance Disorders	F19.24	Other (or unknown) substance - Induced Depressive Disorder, With moderate or severe use disorder	N	Υ
Combined Other Substance Disorders	F19.24	Other (or unknown) substance - Induced Depressive/Bipolar/Related Disorder, With moderate or severe use disorder	N	Y
Combined Other Substance Disorders	F19.259	Other (or unknown) Substance-Induced Psychotic Disorder, With moderate or severe use disorder	N	Υ
Combined Other Substance Disorders	F19.27	Other (or unknown) substance - induced major neurocognitive disorder) With moderate or severe use disorder	N	Υ
Combined Other Substance Disorders	F19.280	Other (or unknown) substance - Induced Anxiety Disorder, With moderate or severe use disorder	N	Υ
Combined Other Substance Disorders	F19.281	Other (or unknown) Substance- Induced Sexual Dysfunction, With moderate or severe use disorder	N	Υ
Combined Other Substance Disorders	F19.282	Other (or unknown) Substance-Induced Sleep Disorder, With moderate or severe use disorder	N	Υ
Combined Other Substance Disorders	F19.288	Other (or unknown) substance-induced mild neurocognitive disorder, With moderate or severe use disorder	N	Υ
Combined Other Substance Disorders	F19.288	Other (or unknown) substance- Induced Obsessive- Compulsive and Related Disorder, With moderate or severe use disorder	N	Y
Combined Other Substance Disorders	F19.288	Other (or unknown) substance- Induced mild neurocognitive/Obsessive-Compulsive/Related Disorder, With moderate or severe use disorder	N	Y
Combined Other Substance Disorders	F19.921	Other (or unknown) substance intoxication Delirium, Without use disorder	N	Υ
Combined Other Substance Disorders	F19.929	Other (or Unknown) Substance Intoxication - Without Use Disorder	N	Υ
Combined Other Substance Disorders	F19.94	Other (or unknown) substance - Induced Bipolar and Related Disorder, Without use disorder	N	Υ
Combined Other Substance Disorders	F19.94	Other (or unknown) substance - Induced Depressive Disorder, Without use disorder	N	Υ
Combined Other Substance Disorders	F19.94	Other (or unknown) substance - Induced Depressive/Bipolar/Related Disorder, Without use disorder	N	Y

Diagnostic Category	ICD-10 DX Code	Diagnostic Description ICD-10	BH MH	BH SU
Combined Other Substance Disorders	F19.959	Other (or unknown) substance Induced Psychotic Disorder, Without use disorder		Υ
Combined Other Substance Disorders	F19.97	Other (or unknown) substance-induced major neurocognitive disorder, Without use disorder	N	Υ
Combined Other Substance Disorders	F19.980	Other (or unknown) substance - Induced Anxiety Disorder, Without use disorder	N	Υ
Combined Other Substance Disorders	F19.981	Other (or unknown) Substance-Induced Sexual Dysfunction, Without use disorder	N	Υ
Combined Other Substance Disorders	F19.988	Other (or unknown) substance mild neurocognitive disorder Without use disorder	N	Υ
Combined Other Substance Disorders	F19.988	Other (or unknown) substance- Induced Obsessive- Compulsive and Related Disorder, Without use disorder	N	Υ
Combined Other Substance Disorders	F19.988	Other (or unknown) substance- Induced mild neurocognitive/Obsessive-Compulsive/Related Disorder, Without use disorder	N	Υ
Combined Other Substance Disorders	F19.99	Unspecified Other (or Unknown) Substance–Related Disorder	N	Υ
Schizophrenia Spectrum and Other Psychotic Disorders	F20.81	Schizophreniform Disorder	Υ	N
Schizophrenia Spectrum and Other Psychotic Disorders	F20.9	Schizophrenia	Υ	N
Personality Disorders	F21	Schizotypal Personality Disorder	Υ	N
Schizophrenia Spectrum and Other Psychotic Disorders	F21	Schizotypal (Personality) Disorder	Υ	N
Schizophrenia Spectrum and Other Psychotic Disorders	F22	Delusional Disorder	Υ	N
Schizophrenia Spectrum and Other Psychotic Disorders	F23	Brief Psychotic Disorder	Υ	N
Schizophrenia Spectrum and Other Psychotic Disorders	F25.0	Schizoaffective Disorder Bipolar Type	Υ	N
Schizophrenia Spectrum and Other Psychotic Disorders	F25.1	Schizoaffective Disorder Depressive Type	Υ	N
Schizophrenia Spectrum and Other Psychotic Disorders	F28	Other Specified Schizophrenia Spectrum and Other Psychotic Disorder	Υ	N
Schizophrenia Spectrum and Other Psychotic Disorders	F29	Unspecified Schizophrenia Spectrum and Other Psychotic Disorder	Υ	N
Bipolar and Related Disorders	F31.0	Bipolar I Disorder Current or most recent episode hypomanic	Υ	N
Bipolar and Related Disorders	F31.11	Bipolar I Disorder Current or most recent episode manic - Mild	Υ	N
Bipolar and Related Disorders	F31.12	Bipolar I Disorder Current or most recent episode manic - Moderate		N
Bipolar and Related Disorders	F31.13	Bipolar I Disorder Current or most recent episode manic - Severe		N
Bipolar and Related Disorders	F31.2	Bipolar I Disorder Current or most recent episode manic - with Psychotic Features	Υ	N
Bipolar and Related Disorders	F31.31	Bipolar I Disorder Current or most recent episode depressed - Mild	Υ	N

Diagnostic Category	ICD-10 DX Code	Diagnostic Description ICD-10	BH MH	BH SU
Bipolar and Related Disorders	F31.32	Bipolar I Disorder Current or most recent episode depressed - Moderate	Υ	N
Bipolar and Related Disorders	F31.4	Bipolar I Disorder Current or most recent episode depressed - Severe	Υ	N
Bipolar and Related Disorders	F31.5	Bipolar I Disorder Current or most recent episode depressed - with Psychotic Features	Υ	N
Bipolar and Related Disorders	F31.71	Bipolar I Disorder Current or most recent episode hypomanic - in partial remission	Υ	N
Bipolar and Related Disorders	F31.72	Bipolar I Disorder Current or most recent episode hypomanic - in full remission	Υ	N
Bipolar and Related Disorders	F31.73	Bipolar I Disorder Current or most recent episode manic - In Partial Remission	Υ	N
Bipolar and Related Disorders	F31.74	Bipolar I Disorder Current or most recent episode manic - In Full Remission	Υ	N
Bipolar and Related Disorders	F31.75	Bipolar I Disorder Current or most recent episode depressed - In Partial Remission	Υ	N
Bipolar and Related Disorders	F31.76	Bipolar I Disorder Current or most recent episode depressed - In Full Remission	Υ	N
Bipolar and Related Disorders	F31.81	Bipolar II Disorder	Υ	N
Bipolar and Related Disorders	F31.89	Other Specified Bipolar and Related Disorder	Υ	N
Bipolar and Related Disorders	F31.9	Bipolar I Disorder Current or most recent episode hypomanic - unspecified	Υ	N
Bipolar and Related Disorders	F31.9	Bipolar I Disorder Current or most recent episode manic - Unspecified	Υ	N
Bipolar and Related Disorders	F31.9	Bipolar I Disorder Current or most recent episode depressed - Unspecified	Υ	N
Bipolar and Related Disorders	F31.9	Bipolar I Disorder Current or most recent episode unspecified	Υ	N
Bipolar and Related Disorders	F31.9	Unspecified Bipolar and Related Disorder	Υ	N
Bipolar and Related Disorders	F31.9	Bipolar Disorder - Unspecified	Υ	N
Depressive Disorders	F32.0	Major Depressive Disorder, Single Episode -Mild	Υ	N
Depressive Disorders	F32.1	Major Depressive Disorder, Single Episode -Moderate	Υ	N
Depressive Disorders	F32.2	Major Depressive Disorder, Single Episode -Severe	Υ	N
Depressive Disorders	F32.3	Major Depressive Disorder, Single Episode -with Psychotic Features	Υ	N
Depressive Disorders	F32.4	Major Depressive Disorder, Single Episode -in Partial Remission	Υ	N
Depressive Disorders	F32.5	Major Depressive Disorder, Single Episode -in Full Remission	Υ	N
Depressive Disorders	F32.8	Other Specified Depressive Disorder	Υ	N
Depressive Disorders	F32.9	Major Depressive Disorder, Single Episode - Unspecified	Υ	N
Depressive Disorders	F32.9	Unspecified Depressive Disorder	Υ	N
Depressive Disorders	F33.0	Major Depressive Disorder, Recurrent Episode -Mild	Υ	N
Depressive Disorders	F33.1	Major Depressive Disorder, Recurrent Episode -	Υ	N

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Moderate

Diagnostic Category	ICD-10 DX Code	Diagnostic Description ICD-10	BH MH	BH SU
Depressive Disorders	F33.2	Major Depressive Disorder, Recurrent Episode - Severe		N
Depressive Disorders	F33.3	Major Depressive Disorder, Recurrent Episode -with Psychotic Features	Υ	N
Depressive Disorders	F33.41	Major Depressive Disorder, Recurrent Episode -in Partial Remission	Υ	N
Depressive Disorders	F33.42	Major Depressive Disorder, Recurrent Episode -in Full Remission	Υ	N
Depressive Disorders	F33.9	Major Depressive Disorder, Recurrent Episode - Unspecified	Υ	N
Bipolar and Related Disorders	F34.0	Cyclothymic Disorder	Υ	N
Depressive Disorders	F34.1	Persistent Depressive Disorder (Dysthymia)	Υ	N
Depressive Disorders	F34.8	Disruptive Mood Dysregulation Disorder	Υ	N
Anxiety Disorders	F40.00	Agoraphobia	Υ	N
Anxiety Disorders	F40.10	Social Anxiety Disorder (Social Phobia)	Υ	N
Anxiety Disorders	F40.218	Specific Phobia - Animal	Υ	N
Anxiety Disorders	F40.228	Specific Phobia - Natural Environment	Υ	N
Anxiety Disorders	F40.230	Specific Phobia - Fear of Blood	Υ	N
Anxiety Disorders	F40.231	Specific Phobia - Fear of Injections and Transfusions	Υ	N
Anxiety Disorders	F40.232	Specific Phobia - Fear of Other Medical Care	Υ	N
Anxiety Disorders	F40.233	Specific Phobia - Fear of Injury	Υ	N
Anxiety Disorders	F40.248	Specific Phobia - Situational	Υ	N
Anxiety Disorders	F40.298	Specific Phobia - Other	Υ	N
Anxiety Disorders	F41.0	Panic Disorder	Υ	N
Anxiety Disorders	F41.1	Generalized Anxiety Disorder	Υ	N
Anxiety Disorders	F41.8	Other Specified Anxiety Disorder	Υ	N
Anxiety Disorders	F41.9	Unspecified Anxiety Disorder	Υ	N
Obsessive-Compulsive and Related Disorders	F42	Hoarding Disorder	Υ	N
Obsessive-Compulsive and Related Disorders	F42	Obsessive-Compulsive Disorder	Υ	N
Obsessive-Compulsive and Related Disorders	F42	Other Specified Obsessive-Compulsive and Related Disorder	Υ	N
Obsessive-Compulsive and Related Disorders	F42	Unspecified Obsessive-Compulsive and Related Disorder	Υ	N
Personality Disorders	F42	Obsessive-Compulsive Disorder	Υ	N
Personality Disorders	F42	Obsessive-Compulsive Disorder, other	Υ	N
Trauma- and Stressor-Related Disorders	F43.0	Acute Stress Disorder	Υ	N
Trauma- and Stressor-Related Disorders	F43.10	Posttraumatic Stress Disorder	Υ	N
Trauma- and Stressor-Related Disorders	F43.20	Adjustment Disorders - Unspecified	Υ	N
Trauma- and Stressor-Related Disorders	F43.21	Adjustment Disorder with depressed mood, Persistent	Υ	N

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Diagnostic Category	ICD-10 DX Code	Diagnostic Description ICD-10	BH MH	BH SU
Trauma- and Stressor-Related Disorders	I F43 // I Adjustment Disorders with Anyiety		Υ	N
Trauma- and Stressor-Related Disorders	F43.23	Adjustment Disorders with Mixed Anxiety and Depressed Mood	Υ	N
Trauma- and Stressor-Related Disorders	F43.24	Adjustment Disorders with Disturbance of Conduct	Υ	N
Trauma- and Stressor-Related Disorders	F43.25	Adjustment Disorders with Mixed Disturbance of Emotions and Conduct	Υ	N
Trauma- and Stressor-Related Disorders	F43.8	Other Specified Trauma- and Stressor-Related Disorder	Υ	N
Trauma- and Stressor-Related Disorders	F43.9	Unspecified Trauma- and Stressor-Related Disorder	Υ	N
Dissociative Disorders	F44.0	Dissociative Amnesia	Υ	N
Dissociative Disorders	F44.1	Dissociative Amnesia WITH Dissociative Fugue	Υ	N
Somatic Symptom and Related Disorders	F44.4	Conversion Disorder (Functional Neurological Symptom Disorder) with Abnormal Movement	Υ	N
Somatic Symptom and Related Disorders	F44.4	Conversion Disorder (Functional Neurological Symptom Disorder) with Speech Symptom	Υ	N
Somatic Symptom and Related Disorders	F44.4	Conversion Disorder (Functional Neurological Symptom Disorder) with Swallowing Symptoms	Υ	N
Somatic Symptom and Related Disorders	F44.4	Conversion Disorder (Functional Neurological Symptom Disorder) with Weakness or Paralysis	Υ	N
Somatic Symptom and Related Disorders	F44.4	Conversion Disorder (Functional Neurological Symptom Disorder) - other physical impairment	Υ	N
Somatic Symptom and Related Disorders	F44.5	Conversion Disorder (Functional Neurological Symptom Disorder) with Attacks or Seizures	Υ	N
Somatic Symptom and Related Disorders	F44.6	Conversion Disorder (Functional Neurological Symptom Disorder) with Anesthesia or Sensory Loss	Υ	N
Somatic Symptom and Related Disorders	F44.6	Conversion Disorder (Functional Neurological Symptom Disorder) with Special Sensory Symptom	Υ	N
Somatic Symptom and Related Disorders	F44.6	Conversion Disorder (Functional Neurological Symptom Disorder) - other sensory impairment	Υ	N
Somatic Symptom and Related Disorders	F44.7	Conversion Disorder (Functional Neurological Symptom Disorder) with Mixed Symptoms	Υ	N
Dissociative Disorders	F44.81	Dissociative Identity Disorder	Υ	N
Dissociative Disorders	F44.89	Other Specified Dissociative Disorder	Υ	N
Dissociative Disorders	F44.9	Unspecified Dissociative Disorder	Υ	N
Somatic Symptom and Related Disorders	F45.1	Somatic Symptom Disorder	Υ	N
Somatic Symptom and Related Disorders	F45.21	Illness Anxiety Disorder	Υ	N
Obsessive-Compulsive and Related Disorders	F45.22	Body Dysmorphic Disorder	Υ	N
Somatic Symptom and Related Disorders	F45.8	Other Specified Somatic Symptom and Related Disorder	Υ	N
Somatic Symptom and Related Disorders	F45.9	Unspecified Somatic Symptom and Related Disorder	Υ	N

Diagnostic Category	ICD-10 DX Code	Diagnostic Description ICD-10	BH MH	BH SU
Dissociative Disorders	F48.1	Depersonalization/Derealization Disorder	Υ	N
Feeding and Eating Disorders - Anorexia & Bulimia	F50.01	Anorexia Nervosa - Restricting Type	Е	N
Feeding and Eating Disorders - Anorexia & Bulimia	F50.02	Anorexia Nervosa - Binge-eating/Purging Type	Е	N
Feeding and Eating Disorders - Anorexia & Bulimia	F50.2	Bulimia Nervosa	Е	N
Feeding and Eating Disorders - Binge Eating	F50.8	Binge-Eating Disorder	Е	N
Feeding and Eating Disorders - Other	F50.8	Pica in adults	Е	N
Feeding and Eating Disorders - Other	F50.8	Avoidant/Restrictive Food Intake Disorder	Е	N
Feeding and Eating Disorders - Other	F50.8	Other Specified Feeding or Eating Disorder	Е	N
Feeding and Eating Disorders - Other	F50.8	Feeding / Eating Disorder - other	Е	N
Feeding and Eating Disorders - Other	F50.9	Unspecified Feeding or Eating Disorder	Е	N
Sleep-Wake Disorders	F51.01	Insomnia Disorder	Е	N
Sleep-Wake Disorders	F51.11	Hypersomnolence Disorder	Е	N
Sleep-Wake Disorders	F51.4	Non-Rapid Eye Movement Sleep Arousal Disorders - Sleep Terrors	Е	N
Sleep-Wake Disorders	F51.5	Nightmare Disorder	Е	N
Somatic Symptom and Related Disorders	F54	Psychological Factors Affecting Other Medical Conditions	Е	N
Personality Disorders	F60.0	Paranoid Personality Disorder	Υ	N
Personality Disorders	F60.1	Schizoid Personality Disorder	Υ	N
Disruptive, Impulse-Control, and Conduct Disorders	F60.2	Antisocial Personality Disorder	Υ	N
Personality Disorders	F60.2	Antisocial Personality Disorder	Υ	N
Personality Disorders	F60.3	Borderline Personality Disorder	Υ	N
Personality Disorders	F60.4	Histrionic Personality Disorder	Υ	N
Personality Disorders	F60.6	Avoidant Personality Disorder	Υ	N
Personality Disorders	F60.7	Dependent Personality Disorder	Υ	N
Personality Disorders	F60.81	Narcissistic Personality Disorder	Υ	N
Personality Disorders	F60.89	Other Specified Personality Disorder	Υ	N
Personality Disorders	F60.9	Unspecified Personality Disorder	Υ	N
Combined Other Substance Disorders	F63.0	Gambling Disorder	Е	N
Disruptive, Impulse-Control, and Conduct Disorders	F63.1	Pyromania	Υ	N
Disruptive, Impulse-Control, and Conduct Disorders	F63.2	Kleptomania	Υ	N
Obsessive-Compulsive and Related Disorders	F63.3	Trichotillomania (Hair-Pulling Disorder)	Υ	N

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Diagnostic Category	ICD-10 DX Code	Diagnostic Description ICD-10	BH MH	BH SU
Disruptive, Impulse-Control, and Conduct Disorders	F63.81	Intermittent Explosive Disorder		N
Gender Dysphoria	F64.1	Gender Dysphoria in Adolescents and Adults	Υ	N
Gender Dysphoria	F64.8	Other Specified Gender Dysphoria	Υ	N
Gender Dysphoria	F64.9	Unspecified Gender Dysphoria	Υ	N
Paraphilic Disorders	F65.1	Transvestic Disorder	Е	N
Paraphilic Disorders	F65.4	Pedophilic Disorder	Е	N
Paraphilic Disorders	F65.52	Sexual Sadism Disorder	Е	N
Somatic Symptom and Related Disorders	F68.10	Factitious Disorder	Е	N
Intellectual Disabilities	F70	Intellectual Disability (Intellectual Developmental Disorder) - Mild	N	N
Intellectual Disabilities	F71	Intellectual Disability (Intellectual Developmental Disorder) - Moderate	N	N
Intellectual Disabilities	F72	Intellectual Disability (Intellectual Developmental Disorder) - Severe	N	N
Intellectual Disabilities	F73	Intellectual Disability (Intellectual Developmental Disorder) - Profound	N	N
Intellectual Disabilities	F78.A	Other genetic related intellectual disabilities	N	N
Intellectual Disabilities	F78.A1	SYNGAP1-related intellectual disability	N	N
Intellectual Disabilities	F78.A9	Other genetic related intellectual disability	N	N
Intellectual Disabilities	F79	Unspecified Intellectual Disability (Intellectual Developmental Disorder)	N	N
Autism Spectrum Disorder	F84.0	Autism Spectrum Disorder	N	N
Intellectual Disabilities	F88	Global Developmental Delay	N	N
Other Neurodevelopmental Disorders	F88	Other Specified Neurodevelopmental Disorder	N	N
Other Neurodevelopmental Disorders	F88	Intellectual Disabilities, Neurodevelopmental Disorder - other	N	N
Other Neurodevelopmental Disorders	F89	Unspecified Neurodevelopmental Disorder	N	N
Trauma- and Stressor-Related Disorders	F90.0	Attention-Deficit/Hyperactivity Disorder Predominantly inattentive presentation	Υ	N
Trauma- and Stressor-Related Disorders	F90.1	Attention-Deficit/Hyperactivity Disorder Predominantly hyperactive/impulsive presentation	Υ	N
Trauma- and Stressor-Related Disorders	F90.2	Attention-Deficit/Hyperactivity Disorder Combined Presentation	Υ	N
Trauma- and Stressor-Related Disorders	F90.8	Other Specified Attention-Deficit/Hyperactivity Disorder	Υ	N
Trauma- and Stressor-Related Disorders	F90.9	Unspecified Attention-Deficit/Hyperactivity Disorder	Υ	N
Disruptive, Impulse-Control, and Conduct Disorders	F91.1	Conduct Disorder - Childhood-onset Type	Υ	N
Disruptive, Impulse-Control, and Conduct Disorders	F91.2	Conduct Disorder - Adolescent-onset Type	Υ	N
Disruptive, Impulse-Control, and Conduct Disorders	F91.3	Oppositional Defiant Disorder	Υ	N

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Diagnostic Category	ICD-10 DX Code	Diagnostic Description ICD-10	BH MH	BH SU
Disruptive, Impulse-Control, and Conduct Disorders	F91.8	Other Specified Disruptive, Impulse-Control, and Conduct Disorder		N
Disruptive, Impulse-Control, and Conduct Disorders	F91.9	Conduct Disorder - Unspecified Onset	Υ	N
Disruptive, Impulse-Control, and Conduct Disorders	F91.9	Unspecified Disruptive, Impulse-Control, and Conduct Disorder	Υ	N
Disruptive, Impulse-Control, and Conduct Disorders	F91.9	Disruptive, Impulse-Control, and Conduct Disorders - other	Υ	N
Anxiety Disorders	F93.0	Separation Anxiety Disorder	Υ	N
Disruptive, Impulse-Control, and Conduct Disorders	F94.0	Selective Mutism	Υ	N
Trauma- and Stressor-Related Disorders	F94.1	Reactive Attachment Disorder	Υ	N
Trauma- and Stressor-Related Disorders	F94.2	Disinhibited Social Engagement Disorder	Υ	N
Elimination Disorders	F98.0	Enuresis	Е	N
Elimination Disorders	F98.1	Encopresis	Е	N
Feeding and Eating Disorders - Other	F98.21	Rumination Disorder	Е	N
Feeding and Eating Disorders - Other	F98.3	Pica in Children	Е	N
Other Mental Disorders	F99	Other Specified Mental Disorder	Е	N
Other Mental Disorders	F99	Unspecified Mental Disorder	Е	N
Other Mental Disorders	F99	Other Specified/Unspecified Mental Disorder	Е	N
Sleep-Wake Disorders	G47.00	Unspecified Insomnia Disorder	Е	N
Sleep-Wake Disorders	G47.09	Other Specified Insomnia Disorder	Е	N
Sleep-Wake Disorders	G47.10	Unspecified Hypersomnolence Disorder	Е	N
Sleep-Wake Disorders	G47.19	Other Specified Hypersomnolence Disorder	Е	N
Sleep-Wake Disorders	G47.20	Circadian Rhythm Sleep-Wake Disorders - Unspecified Type	Е	N
Sleep-Wake Disorders	G47.21	Circadian Rhythm Sleep-Wake Disorders - Delayed Sleep Phase Type	Е	N
Sleep-Wake Disorders	G47.22	Circadian Rhythm Sleep-Wake Disorders - Advanced Sleep Phase Type	Е	N
Sleep-Wake Disorders	G47.23	Circadian Rhythm Sleep-Wake Disorders - Irregular Sleep-wake Type	Е	N
Sleep-Wake Disorders	G47.24	Circadian Rhythm Sleep-Wake Disorders Non-24- hour Sleep-wake Type	Е	N
Sleep-Wake Disorders	G47.26	Circadian Rhythm Sleep-Wake Disorders -Shift Work Type	Е	N
Obsessive-Compulsive and Related Disorders	L98.1	Excoriation (Skin-Picking) Disorder	Υ	N

APPENDIX C: CLAIMS DIAGNOSIS

Specific to the claims that are submitted to the ASO, the following are allowable claims diagnoses. A list of valid ICD-10 diagnosis codes for claim submission are outlined below. Providers will note that there are additional codes that are acceptable for claims that are not valid codes for authorization purposes. This flexibility was included as providers may not know all possible diagnoses at the point in time of authorization. There may be diagnoses being treated that are appropriate for billing that are not on the authorization.

Additionally, this list is not all inclusive of diagnosis descriptions. For instance, F06.1 is listed here as *Catatonic disorder due to known physiological condition*. F06.1 also represents several other descriptions such as *Catatonic Disorder Due to Another Medical Condition*. The provider is allowed to submit claims for the gamut of descriptions associated with that single numerical ICD-CM-10 if it is listed here:

ICD-CM-10	Short Description	Long Description
F983	Pica of infancy and childhood	Pica of infancy and childhood
F630	Pathological gambling	Pathological gambling
F060	Psychotic disorder w hallucin due to known physiol condition	Psychotic disorder with hallucinations due to known physiological condition
F061	Catatonic disorder due to known physiological condition	Catatonic disorder due to known physiological condition
F062	Psychotic disorder w delusions due to known physiol cond	Psychotic disorder with delusions due to known physiological condition
F0630	Mood disorder due to known physiological condition, unsp	Mood disorder due to known physiological condition, unspecified
F0631	Mood disorder due to known physiol cond w depressy features	Mood disorder due to known physiological condition with depressive features
F0632	Mood disord d/t physiol cond w major depressive-like epsd	Mood disorder due to known physiological condition with major depressive-like episode
F0633	Mood disorder due to known physiol cond w manic features	Mood disorder due to known physiological condition with manic features
F0634	Mood disorder due to known physiol cond w mixed features	Mood disorder due to known physiological condition with mixed features
F064	Anxiety disorder due to known physiological condition	Anxiety disorder due to known physiological condition
F070	Personality change due to known physiological condition	Personality change due to known physiological condition
F079	Unsp personality & behavrl disord due to known physiol cond	Unspecified personality and behavioral disorder due to known physiological condition
F09	Unsp mental disorder due to known physiological condition	Unspecified mental disorder due to known physiological condition
F1010	Alcohol abuse, uncomplicated	Alcohol abuse, uncomplicated
F10120	Alcohol abuse with intoxication, uncomplicated	Alcohol abuse with intoxication, uncomplicated
F10121	Alcohol abuse with intoxication delirium	Alcohol abuse with intoxication delirium
F10129	Alcohol abuse with intoxication, unspecified	Alcohol abuse with intoxication, unspecified
F10130	Alcohol abuse with withdrawal, uncomplicated	Alcohol abuse with withdrawal, uncomplicated
F10131	Alcohol abuse with withdrawal delirium	Alcohol abuse with withdrawal delirium

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ICD-CM-10	Short Description	Long Description
	Alcohol abuse with withdrawal with	
F10132	perceptual disturbance	Alcohol abuse with withdrawal with perceptual disturbance
F10139	Alcohol abuse with withdrawal, unspecified	Alcohol abuse with withdrawal, unspecified
	Alcohol abuse with alcohol-induced mood	, ,
F1014	disorder	Alcohol abuse with alcohol-induced mood disorder
	Alcohol abuse w alcoh-induce psychotic	Alcohol abuse with alcohol-induced psychotic disorder with
F10150	disorder w delusions	delusions
	Alcohol abuse w alcoh-induce psychotic	Alcohol abuse with alcohol-induced psychotic disorder with
F10151	disorder w hallucin	hallucinations
	Alcohol abuse with alcohol-induced	
F10159	psychotic disorder, unsp	Alcohol abuse with alcohol-induced psychotic disorder, unspecified
	Alcohol abuse with alcohol-induced anxiety	
F10180	disorder	Alcohol abuse with alcohol-induced anxiety disorder
	Alcohol abuse with alcohol-induced sexual	
F10181	dysfunction	Alcohol abuse with alcohol-induced sexual dysfunction
	Alcohol abuse with alcohol-induced sleep	
F10182	disorder	Alcohol abuse with alcohol-induced sleep disorder
	Alcohol abuse with other alcohol-induced	
F10188	disorder	Alcohol abuse with other alcohol-induced disorder
	Alcohol abuse with unspecified alcohol-	
F1019	induced disorder	Alcohol abuse with unspecified alcohol-induced disorder
F1020	Alcohol dependence, uncomplicated	Alcohol dependence, uncomplicated
F1021	Alcohol dependence, in remission	Alcohol dependence, in remission
		,
E10000	Alcohol dependence with intoxication,	Alachal danandanas with intervination, unacomplicated
F10220	uncomplicated Alcohol dependence with intoxication	Alcohol dependence with intoxication, uncomplicated
F10221	delirium	Alcohol dependence with intoxication delirium
1 10221	Alcohol dependence with intoxication,	Alcohol dependence with intoxication definition
F10229	unspecified	Alcohol dependence with intoxication, unspecified
1 10223	Alcohol dependence with withdrawal,	Alcohol dependence with intoxication, unspecified
F10230	uncomplicated	Alcohol dependence with withdrawal, uncomplicated
1 10200	Alcohol dependence with withdrawal	74001101 dependence with withdrawar, anothipheated
F10231	delirium	Alcohol dependence with withdrawal delirium
	Alcohol dependence w withdrawal with	
F10232	perceptual disturbance	Alcohol dependence with withdrawal with perceptual disturbance
	Alcohol dependence with withdrawal,	
F10239	unspecified	Alcohol dependence with withdrawal, unspecified
	Alcohol dependence with alcohol-induced	
F1024	mood disorder	Alcohol dependence with alcohol-induced mood disorder
	Alcohol depend w alcoh-induce psychotic	Alcohol dependence with alcohol-induced psychotic disorder with
F10250	disorder w delusions	delusions
	Alcohol depend w alcoh-induce psychotic	Alcohol dependence with alcohol-induced psychotic disorder with
F10251	disorder w hallucin	hallucinations
	Alcohol dependence w alcoh-induce	Alcohol dependence with alcohol-induced psychotic disorder,
F10259	psychotic disorder, unsp	unspecified
	Alcohol depend w alcoh-induce persisting	Alcohol dependence with alcohol-induced persisting amnestic
F1026	amnestic disorder	disorder
	Alcohol dependence with alcohol-induced	
F1027	persisting dementia	Alcohol dependence with alcohol-induced persisting dementia
	Alcohol dependence with alcohol-induced	
F10280	anxiety disorder	Alcohol dependence with alcohol-induced anxiety disorder

ICD-CM-10	Short Description	Long Description
	Alcohol dependence with alcohol-induced	
F10281	sexual dysfunction	Alcohol dependence with alcohol-induced sexual dysfunction
	Alcohol dependence with alcohol-induced	
F10282	sleep disorder	Alcohol dependence with alcohol-induced sleep disorder
	Alcohol dependence with other alcohol-	
F10288	induced disorder	Alcohol dependence with other alcohol-induced disorder
	Alcohol dependence with unspecified	
F1029	alcohol-induced disorder	Alcohol dependence with unspecified alcohol-induced disorder
E40000	Alcohol use, unspecified with intoxication,	
F10920	uncomplicated	Alcohol use, unspecified with intoxication, uncomplicated
E40004	Alcohol use, unspecified with intoxication	Alachal was was sified with interview to a livium
F10921	delirium	Alcohol use, unspecified with intoxication delirium
E10000	Alcohol use, unspecified with intoxication,	Alachal was unanceified with interioration unanceified
F10929	unspecified Alcohol use, unspecified with withdrawal,	Alcohol use, unspecified with intoxication, unspecified
F10930	uncomplicated	Alcohol use, unspecified with withdrawal, uncomplicated
1 10950	Alcohol use, unspecified with withdrawal	Alconor use, unspecified with withdrawar, uncomplicated
F10931	delirium	Alcohol use, unspecified with withdrawal delirium
1 10331	Alcohol use, unspecified with withdrawal	Alcohol use, unspecified with withdrawal with perceptual
F10932	with perceptual disturbance	disturbance
1 10002	Alcohol use, unspecified with withdrawal,	distansanios
F10939	unspecified	Alcohol use, unspecified with withdrawal, unspecified
1 10000	Alcohol use, unspecified with alcohol-	7 Hooriot doo, direpromod mar maidrandi, direpromod
F1094	induced mood disorder	Alcohol use, unspecified with alcohol-induced mood disorder
	Alcohol use, unsp w alcoh-induce psych	Alcohol use, unspecified with alcohol-induced psychotic disorder
F10950	disorder w delusions	with delusions
	Alcohol use, unsp w alcoh-induce psych	Alcohol use, unspecified with alcohol-induced psychotic disorder
F10951	disorder w hallucin	with hallucinations
	Alcohol use, unsp w alcohol-induced	Alcohol use, unspecified with alcohol-induced psychotic disorder,
F10959	psychotic disorder, unsp	unspecified
	Alcohol use, unsp w alcoh-induce persist	Alcohol use, unspecified with alcohol-induced persisting amnestic
F1096	amnestic disorder	disorder
	Alcohol use, unsp with alcohol-induced	
F1097	persisting dementia	Alcohol use, unspecified with alcohol-induced persisting dementia
	Alcohol use, unsp with alcohol-induced	
F10980	anxiety disorder	Alcohol use, unspecified with alcohol-induced anxiety disorder
E40004	Alcohol use, unsp with alcohol-induced	Alaskalasa arang Kada Malaskalaskalaskalaskalaskalaskalaska
F10981	sexual dysfunction	Alcohol use, unspecified with alcohol-induced sexual dysfunction
E10092	Alcohol use, unspecified with alcohol-	Alashal use unanacified with alashal indused alash disorder
F10982	induced sleep disorder	Alcohol use, unspecified with alcohol-induced sleep disorder
F10988	Alcohol use, unspecified with other alcohol-induced disorder	Alcohol use, unspecified with other alcohol-induced disorder
1 10300	Alcohol use, unsp with unspecified alcohol-	Alcohol use, unspecified with other alcohol-muted disorder
F1099	induced disorder	Alcohol use, unspecified with unspecified alcohol-induced disorder
		·
F1110	Opioid abuse, uncomplicated	Opioid abuse, uncomplicated
F11120	Opioid abuse with intoxication, uncomplicated	Opioid abuse with intoxication, uncomplicated
F11121	Opioid abuse with intoxication delirium	Opioid abuse with intoxication delirium
E44400	Opioid abuse with intoxication with	Onicid above with interior time with a second of P. C.
F11122	perceptual disturbance	Opioid abuse with intoxication with perceptual disturbance
F11129	Opioid abuse with intoxication, unspecified	Opioid abuse with intoxication, unspecified
F1113	Opioid abuse with withdrawal	Opioid abuse with withdrawal

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ICD-CM-10	Short Description	Long Description
	Opioid abuse with opioid-induced mood	
F1114	disorder	Opioid abuse with opioid-induced mood disorder
=444=0	Opioid abuse w opioid-induced psychotic	Opioid abuse with opioid-induced psychotic disorder with
F11150	disorder w delusions	delusions
E444E4	Opioid abuse w opioid-induced psychotic	Opioid abuse with opioid-induced psychotic disorder with
F11151	disorder w hallucin	hallucinations
E111E0	Opioid abuse with opioid-induced	Onicid abuse with enicid induced payabotic dicorder upopositied
F11159	psychotic disorder, unsp Opioid abuse with opioid-induced sexual	Opioid abuse with opioid-induced psychotic disorder, unspecified
F11181	dysfunction	Opioid abuse with opioid-induced sexual dysfunction
1 11101	Opioid abuse with opioid-induced sleep	Opiola abuse with opiola-induced sexual dysiunction
F11182	disorder	Opioid abuse with opioid-induced sleep disorder
1 11102	Opioid abuse with other opioid-induced	Opiola abase with opiola maacca sleep alsorael
F11188	disorder	Opioid abuse with other opioid-induced disorder
1 11100	Opioid abuse with unspecified opioid-	Spicia abace with other spicia madeda dicerasi
F1119	induced disorder	Opioid abuse with unspecified opioid-induced disorder
F1120	Opioid dependence, uncomplicated	Opioid dependence, uncomplicated
F1121	Opioid dependence, in remission	Opioid dependence, in remission
E44000	Opioid dependence with intoxication,	Onicid domandones with interioration was applicated
F11220	uncomplicated	Opioid dependence with intoxication, uncomplicated
F11221	Opioid dependence with intoxication delirium	Onicid dependence with intervication delirium
ГПИИ	Opioid dependence w intoxication with	Opioid dependence with intoxication delirium
F11222	perceptual disturbance	Opioid dependence with intoxication with perceptual disturbance
1 11222	Opioid dependence with intoxication,	Opioid dependence with intoxication with perceptual disturbance
F11229	unspecified	Opioid dependence with intoxication, unspecified
	'	
F1123	Opioid dependence with withdrawal	Opioid dependence with withdrawal
F1124	Opioid dependence with opioid-induced mood disorder	Opioid dependence with opioid-induced mood disorder
1 1124	Opioid depend w opioid-induc psychotic	Opioid dependence with opioid-induced mood disorder with
F11250	disorder w delusions	delusions
1 11200	Opioid depend w opioid-induc psychotic	Opioid dependence with opioid-induced psychotic disorder with
F11251	disorder w hallucin	hallucinations
	Opioid dependence w opioid-induced	Opioid dependence with opioid-induced psychotic disorder,
F11259	psychotic disorder, unsp	unspecified
	Opioid dependence with opioid-induced	
F11281	sexual dysfunction	Opioid dependence with opioid-induced sexual dysfunction
	Opioid dependence with opioid-induced	
F11282	sleep disorder	Opioid dependence with opioid-induced sleep disorder
	Opioid dependence with other opioid-	
F11288	induced disorder	Opioid dependence with other opioid-induced disorder
	Opioid dependence with unspecified	
F1129	opioid-induced disorder	Opioid dependence with unspecified opioid-induced disorder
F1190	Opioid use, unspecified, uncomplicated	Opioid use, unspecified, uncomplicated
	Opioid use, unspecified with intoxication,	
F11920	uncomplicated	Opioid use, unspecified with intoxication, uncomplicated
	Opioid use, unspecified with intoxication	
F11921	delirium	Opioid use, unspecified with intoxication delirium
	Opioid use, unsp w intoxication with	Opioid use, unspecified with intoxication with perceptual
F11922	perceptual disturbance	disturbance
	Opioid use, unspecified with intoxication,	
F11929	unspecified	Opioid use, unspecified with intoxication, unspecified

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ICD-CM-10	Short Description	Long Description
F1193	Opioid use, unspecified with withdrawal	Opioid use, unspecified with withdrawal
	Opioid use, unspecified with opioid-	
F1194	induced mood disorder	Opioid use, unspecified with opioid-induced mood disorder
	Opioid use, unsp w opioid-induc psych	Opioid use, unspecified with opioid-induced psychotic disorder
F11950	disorder w delusions	with delusions
	Opioid use, unsp w opioid-induc psych	Opioid use, unspecified with opioid-induced psychotic disorder
F11951	disorder w hallucin	with hallucinations
	Opioid use, unsp w opioid-induced	Opioid use, unspecified with opioid-induced psychotic disorder,
F11959	psychotic disorder, unsp	unspecified
	Opioid use, unsp with opioid-induced	
F11981	sexual dysfunction	Opioid use, unspecified with opioid-induced sexual dysfunction
	Opioid use, unspecified with opioid-	
F11982	induced sleep disorder	Opioid use, unspecified with opioid-induced sleep disorder
	Opioid use, unspecified with other opioid-	
F11988	induced disorder	Opioid use, unspecified with other opioid-induced disorder
	Opioid use, unsp with unspecified opioid-	
F1199	induced disorder	Opioid use, unspecified with unspecified opioid-induced disorder
F1210	Cannabis abuse, uncomplicated	Cannabis abuse, uncomplicated
	Cannabis abuse with intoxication,	
F12120	uncomplicated	Cannabis abuse with intoxication, uncomplicated
F12121	Cannabis abuse with intoxication delirium	Cannabis abuse with intoxication delirium
	Cannabis abuse with intoxication with	
F12122	perceptual disturbance	Cannabis abuse with intoxication with perceptual disturbance
	Cannabis abuse with intoxication,	
F12129	unspecified	Cannabis abuse with intoxication, unspecified
F1213	Cannabis abuse with withdrawal	Cannabis abuse with withdrawal
1 1210	Cannabis abuse with psychotic disorder	Carriable abase with withdrawar
F12150	with delusions	Cannabis abuse with psychotic disorder with delusions
	Cannabis abuse with psychotic disorder	
F12151	with hallucinations	Cannabis abuse with psychotic disorder with hallucinations
	Cannabis abuse with psychotic disorder,	
F12159	unspecified	Cannabis abuse with psychotic disorder, unspecified
	Cannabis abuse with cannabis-induced	
F12180	anxiety disorder	Cannabis abuse with cannabis-induced anxiety disorder
	Cannabis abuse with other cannabis-	•
F12188	induced disorder	Cannabis abuse with other cannabis-induced disorder
	Cannabis abuse with unspecified	
F1219	cannabis-induced disorder	Cannabis abuse with unspecified cannabis-induced disorder
F1220	Cannabis dependence, uncomplicated	Cannabis dependence, uncomplicated
F1221	Cannabis dependence, in remission	·
1 1441	Cannabis dependence, in remission Cannabis dependence with intoxication,	Cannabis dependence, in remission
F12220	uncomplicated	Cannabis dependence with intoxication, uncomplicated
I IZZZU	Cannabis dependence with intoxication	Carmana dependence with intoxication, uncomplicated
F12221	delirium	Cannabis dependence with intoxication delirium
1 14441	Cannabis dependence w intoxication w	Cannabis dependence with intoxication definitin
F12222	perceptual disturbance	disturbance
1 14444	Cannabis dependence with intoxication,	นเจเนเมิสแบช
F12229	unspecified	Cannabis dependence with intoxication, unspecified
1 14443	Cannabis dependence with psychotic	Odiniabio dependence with intoxication, unspecified
F12250	disorder with delusions	Cannabis dependence with psychotic disorder with delusions
1 12230	GISOLUCI WILLI UCIUSIOLIS	Cannabis dependence with psycholic disorder with defusions

ICD-CM-10	Short Description	Long Description
	Cannabis dependence w psychotic	-
F12251	disorder with hallucinations	Cannabis dependence with psychotic disorder with hallucinations
	Cannabis dependence with psychotic	
F12259	disorder, unspecified	Cannabis dependence with psychotic disorder, unspecified
	Cannabis dependence with cannabis-	
F12280	induced anxiety disorder	Cannabis dependence with cannabis-induced anxiety disorder
	Canada da nandanaa wikhakhan	
F12288	Cannabis dependence with other cannabis-induced disorder	Cannabia danandanaa with other cannabia induced disorder
F12200		Cannabis dependence with other cannabis-induced disorder
F1229	Cannabis dependence with unsp cannabis-induced disorder	Cannabis dependence with unspecified cannabis-induced disorder
		·
F1290	Cannabis use, unspecified, uncomplicated	Cannabis use, unspecified, uncomplicated
E40000	Cannabis use, unspecified with	
F12920	intoxication, uncomplicated	Cannabis use, unspecified with intoxication, uncomplicated
F12921	Cannabis use, unspecified with intoxication delirium	Cannabia use unanceified with intervigation delirium
F 12921		Cannabis use, unspecified with intoxication delirium Cannabis use, unspecified with intoxication with perceptual
F12922	Cannabis use, unsp w intoxication w perceptual disturbance	disturbance
1 12322	Cannabis use, unspecified with	disturbance
F12929	intoxication, unspecified	Cannabis use, unspecified with intoxication, unspecified
1 12323	Cannabis use, unsp with psychotic	Odmidbio doc, driopecined with intoxication, driopecined
F12950	disorder with delusions	Cannabis use, unspecified with psychotic disorder with delusions
1 12000	Cannabis use, unsp w psychotic disorder	Cannabis use, unspecified with psychotic disorder with
F12951	with hallucinations	hallucinations
	Cannabis use, unsp with psychotic	
F12959	disorder, unspecified	Cannabis use, unspecified with psychotic disorder, unspecified
	Cannabis use, unspecified with anxiety	
F12980	disorder	Cannabis use, unspecified with anxiety disorder
	Cannabis use, unsp with other cannabis-	
F12988	induced disorder	Cannabis use, unspecified with other cannabis-induced disorder
	Cannabis use, unsp with unsp cannabis-	Cannabis use, unspecified with unspecified cannabis-induced
F1299	induced disorder	disorder
	Sedative, hypnotic or anxiolytic abuse,	
F1310	uncomplicated	Sedative, hypnotic or anxiolytic abuse, uncomplicated
	Sedatv/hyp/anxiolytc abuse w intoxication,	Sedative, hypnotic or anxiolytic abuse with intoxication,
F13120	uncomplicated	uncomplicated
E40404	Sedatv/hyp/anxiolytc abuse w intoxication	
F13121	delirium	Sedative, hypnotic or anxiolytic abuse with intoxication delirium
E12120	Sedative, hypnotic or anxiolytic abuse w intoxication, unsp	Sedative, hypnotic or anxiolytic abuse with intoxication, unspecified
F13129	Sedative, hypnotic or anxiolytic abuse with	Sedative, hypnotic or anxiolytic abuse with withdrawal,
F13130	withdrawal, uncomplicated	uncomplicated
1 10 100	Sedative, hypnotic or anxiolytic abuse with	anomplicated
F13131	withdrawal delirium	Sedative, hypnotic or anxiolytic abuse with withdrawal delirium
	Sedative, hypnotic or anxiolytic abuse with	Sedative, hypnotic or anxiolytic abuse with withdrawal with
F13132	withdrawal with perceptual disturbance	perceptual disturbance
	Sedative, hypnotic or anxiolytic abuse with	
F13139	withdrawal, unspecified	Sedative, hypnotic or anxiolytic abuse with withdrawal, unspecified
	Sedative, hypnotic or anxiolytic abuse w	Sedative, hypnotic or anxiolytic abuse with sedative, hypnotic or
F1314	mood disorder	anxiolytic-induced mood disorder
	Sedatv/hyp/anxiolytc abuse w psychotic	Sedative, hypnotic or anxiolytic abuse with sedative, hypnotic or
F13150	disorder w delusions	anxiolytic-induced psychotic disorder with delusions

ICD-CM-10	Short Description	Long Description
	Sedatv/hyp/anxiolytc abuse w psychotic	Sedative, hypnotic or anxiolytic abuse with sedative, hypnotic or
F13151	disorder w hallucin	anxiolytic-induced psychotic disorder with hallucinations
	Sedatv/hyp/anxiolytc abuse w psychotic	Sedative, hypnotic or anxiolytic abuse with sedative, hypnotic or
F13159	disorder, unsp	anxiolytic-induced psychotic disorder, unspecified
	Sedative, hypnotic or anxiolytic abuse w	Sedative, hypnotic or anxiolytic abuse with sedative, hypnotic or
F13180	anxiety disorder	anxiolytic-induced anxiety disorder
	Sedative, hypnotic or anxiolytic abuse w	Sedative, hypnotic or anxiolytic abuse with sedative, hypnotic or
F13181	sexual dysfunction	anxiolytic-induced sexual dysfunction
	Sedative, hypnotic or anxiolytic abuse w	Sedative, hypnotic or anxiolytic abuse with sedative, hypnotic or
F13182	sleep disorder	anxiolytic-induced sleep disorder
	Sedative, hypnotic or anxiolytic abuse w	Sedative, hypnotic or anxiolytic abuse with other sedative,
F13188	oth disorder	hypnotic or anxiolytic-induced disorder
	Sedative, hypnotic or anxiolytic abuse w	Sedative, hypnotic or anxiolytic abuse with unspecified sedative,
F1319	unsp disorder	hypnotic or anxiolytic-induced disorder
	Sedative, hypnotic or anxiolytic	
F1320	dependence, uncomplicated	Sedative, hypnotic or anxiolytic dependence, uncomplicated
	Sedative, hypnotic or anxiolytic	
F1321	dependence, in remission	Sedative, hypnotic or anxiolytic dependence, in remission
	Sedatv/hyp/anxiolytc dependence w	Sedative, hypnotic or anxiolytic dependence with intoxication,
F13220	intoxication, uncomp	uncomplicated
	Sedatv/hyp/anxiolytc dependence w	Sedative, hypnotic or anxiolytic dependence with intoxication
F13221	intoxication delirium	delirium
	Sedatv/hyp/anxiolytc dependence w	Sedative, hypnotic or anxiolytic dependence with intoxication,
F13229	intoxication, unsp	unspecified
	Sedatv/hyp/anxiolytc dependence w	Sedative, hypnotic or anxiolytic dependence with withdrawal,
F13230	withdrawal, uncomplicated	uncomplicated
	Sedatv/hyp/anxiolytc dependence w	Sedative, hypnotic or anxiolytic dependence with withdrawal
F13231	withdrawal delirium	delirium
	Sedatv/hyp/anxiolytc depend w w/drawal w	Sedative, hypnotic or anxiolytic dependence with withdrawal with
F13232	perceptual disturb	perceptual disturbance
	Sedatv/hyp/anxiolytc dependence w	Sedative, hypnotic or anxiolytic dependence with withdrawal,
F13239	withdrawal, unsp	unspecified
	Sedative, hypnotic or anxiolytic	Sedative, hypnotic or anxiolytic dependence with sedative,
F1324	dependence w mood disorder	hypnotic or anxiolytic-induced mood disorder
	Sedatv/hyp/anxiolytc depend w psychotic	Sedative, hypnotic or anxiolytic dependence with sedative,
F13250	disorder w delusions	hypnotic or anxiolytic-induced psychotic disorder with delusions
		Sedative, hypnotic or anxiolytic dependence with sedative,
	Sedatv/hyp/anxiolytc depend w psychotic	hypnotic or anxiolytic-induced psychotic disorder with
F13251	disorder w hallucin	hallucinations
E400E0	Sedatv/hyp/anxiolytc dependence w	Sedative, hypnotic or anxiolytic dependence with sedative,
F13259	psychotic disorder, unsp	hypnotic or anxiolytic-induced psychotic disorder, unspecified
E4000	Sedatv/hyp/anxiolytc depend w persisting	Sedative, hypnotic or anxiolytic dependence with sedative,
F1326	amnestic disorder	hypnotic or anxiolytic-induced persisting amnestic disorder
E400=	Sedatv/hyp/anxiolytc dependence w	Sedative, hypnotic or anxiolytic dependence with sedative,
F1327	persisting dementia	hypnotic or anxiolytic-induced persisting dementia
E40000	Sedatv/hyp/anxiolytc dependence w	Sedative, hypnotic or anxiolytic dependence with sedative,
F13280	anxiety disorder	hypnotic or anxiolytic-induced anxiety disorder
E40004	Sedatv/hyp/anxiolytc dependence w sexual	Sedative, hypnotic or anxiolytic dependence with sedative,
F13281	dysfunction	hypnotic or anxiolytic-induced sexual dysfunction
E40000	Sedative, hypnotic or anxiolytic	Sedative, hypnotic or anxiolytic dependence with sedative,
F13282	dependence w sleep disorder	hypnotic or anxiolytic-induced sleep disorder
	Sedative, hypnotic or anxiolytic	Sedative, hypnotic or anxiolytic dependence with other sedative,
F13288	dependence w oth disorder	hypnotic or anxiolytic-induced disorder

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ICD-CM-10	Short Description	Long Description
	Sedative, hypnotic or anxiolytic	Sedative, hypnotic or anxiolytic dependence with unspecified
F1329	dependence w unsp disorder	sedative, hypnotic or anxiolytic-induced disorder
	Sedative, hypnotic, or anxiolytic use, unsp,	, , ,
F1390	uncomplicated	Sedative, hypnotic, or anxiolytic use, unspecified, uncomplicated
	Sedatv/hyp/anxiolytc use, unsp w	Sedative, hypnotic or anxiolytic use, unspecified with intoxication
F13920	intoxication, uncomplicated	uncomplicated
	Sedatv/hyp/anxiolytc use, unsp w	Sedative, hypnotic or anxiolytic use, unspecified with intoxication
F13921	intoxication delirium	delirium
	Sedatv/hyp/anxiolytc use, unsp w	Sedative, hypnotic or anxiolytic use, unspecified with intoxication
F13929	intoxication, unsp	unspecified
	Sedatv/hyp/anxiolytc use, unsp w	Sedative, hypnotic or anxiolytic use, unspecified with withdrawal,
F13930	withdrawal, uncomplicated	uncomplicated
		· ·
	Sedatv/hyp/anxiolytc use, unsp w	Sedative, hypnotic or anxiolytic use, unspecified with withdrawal
F13931	withdrawal delirium	delirium
	Sedatv/hyp/anxiolytc use, unsp w w/drawal	Sedative, hypnotic or anxiolytic use, unspecified with withdrawal
F13932	w perceptl disturb	with perceptual disturbances
	Sedatv/hyp/anxiolytc use, unsp w	Sedative, hypnotic or anxiolytic use, unspecified with withdrawal,
F13939	withdrawal, unsp	unspecified
	Sedative, hypnotic or anxiolytic use, unsp	Sedative, hypnotic or anxiolytic use, unspecified with sedative,
F1394	w mood disorder	hypnotic or anxiolytic-induced mood disorder
	Sedatv/hyp/anxiolytc use, unsp w psych	Sedative, hypnotic or anxiolytic use, unspecified with sedative,
F13950	disorder w delusions	hypnotic or anxiolytic-induced psychotic disorder with delusions
		Sedative, hypnotic or anxiolytic use, unspecified with sedative,
	Sedatv/hyp/anxiolytc use, unsp w psych	hypnotic or anxiolytic-induced psychotic disorder with
F13951	disorder w hallucin	hallucinations
	Sedatv/hyp/anxiolytc use, unsp w	Sedative, hypnotic or anxiolytic use, unspecified with sedative,
F13959	psychotic disorder, unsp	hypnotic or anxiolytic-induced psychotic disorder, unspecified
	Sedatv/hyp/anxiolytc use, unsp w persist	Sedative, hypnotic or anxiolytic use, unspecified with sedative,
F1396	amnestic disorder	hypnotic or anxiolytic-induced persisting amnestic disorder
	Sedatv/hyp/anxiolytc use, unsp w	Sedative, hypnotic or anxiolytic use, unspecified with sedative,
F1397	persisting dementia	hypnotic or anxiolytic-induced persisting dementia
	Sedatv/hyp/anxiolytc use, unsp w anxiety	Sedative, hypnotic or anxiolytic use, unspecified with sedative,
F13980	disorder	hypnotic or anxiolytic-induced anxiety disorder
	Sedatv/hyp/anxiolytc use, unsp w sexual	Sedative, hypnotic or anxiolytic use, unspecified with sedative,
F13981	dysfunction	hypnotic or anxiolytic-induced sexual dysfunction
	Sedative, hypnotic or anxiolytic use, unsp	Sedative, hypnotic or anxiolytic use, unspecified with sedative,
F13982	w sleep disorder	hypnotic or anxiolytic-induced sleep disorder
	Sedative, hypnotic or anxiolytic use, unsp	Sedative, hypnotic or anxiolytic use, unspecified with other
F13988	w oth disorder	sedative, hypnotic or anxiolytic-induced disorder
	Sedative, hypnotic or anxiolytic use, unsp	Sedative, hypnotic or anxiolytic use, unspecified with unspecified
F1399	w unsp disorder	sedative, hypnotic or anxiolytic-induced disorder
F1410	Cocaine abuse, uncomplicated	Cocaine abuse, uncomplicated
•	Cocaine abuse with intoxication.	
F14120	uncomplicated	Cocaine abuse with intoxication, uncomplicated
•	Cocaine abuse with intoxication with	and the same of th
F14121	delirium	Cocaine abuse with intoxication with delirium
	Cocaine abuse with intoxication with	Cooking aways that moradagn that dollidin
F14122	perceptual disturbance	Cocaine abuse with intoxication with perceptual disturbance
	Cocaine abuse with intoxication,	Cooking abase that interfedation that perceptual disturbation
F14129	unspecified	Cocaine abuse with intoxication, unspecified
	Cocaine abuse, unspecified with	Coosino abaso mar monoation, anoposition
F1413	withdrawal	Cocaine abuse, unspecified with withdrawal
		1 2 2 2 2 2 2 2 2 2 2 2 2 2 2 2 2 2 2 2

ICD-CM-10	Short Description	Long Description
F1414	Cocaine abuse with cocaine-induced mood disorder	Cocaine abuse with cocaine-induced mood disorder
F14150	Cocaine abuse w cocaine-induc psychotic disorder w delusions	Cocaine abuse with cocaine-induced psychotic disorder with delusions
F14151	Cocaine abuse w cocaine-induc psychotic disorder w hallucin	Cocaine abuse with cocaine-induced psychotic disorder with hallucinations
F14159	Cocaine abuse with cocaine-induced psychotic disorder, unsp	Cocaine abuse with cocaine-induced psychotic disorder, unspecified
F14180	Cocaine abuse with cocaine-induced anxiety disorder	Cocaine abuse with cocaine-induced anxiety disorder
F14181	Cocaine abuse with cocaine-induced sexual dysfunction	Cocaine abuse with cocaine-induced sexual dysfunction
F14182	Cocaine abuse with cocaine-induced sleep disorder	Cocaine abuse with cocaine-induced sleep disorder
F14188	Cocaine abuse with other cocaine-induced disorder	Cocaine abuse with other cocaine-induced disorder
F1419	Cocaine abuse with unspecified cocaine-induced disorder	Cocaine abuse with unspecified cocaine-induced disorder
F1420	Cocaine dependence, uncomplicated	Cocaine dependence, uncomplicated
F1421	Cocaine dependence, in remission	Cocaine dependence, in remission
F14220	Cocaine dependence with intoxication, uncomplicated	Cocaine dependence with intoxication, uncomplicated
F14221	Cocaine dependence with intoxication delirium	Cocaine dependence with intoxication delirium
F14222	Cocaine dependence w intoxication w perceptual disturbance	Cocaine dependence with intoxication with perceptual disturbance
F14229	Cocaine dependence with intoxication, unspecified	Cocaine dependence with intoxication, unspecified
F1423	Cocaine dependence with withdrawal	Cocaine dependence with withdrawal
F1424	Cocaine dependence with cocaine-induced mood disorder	Cocaine dependence with cocaine-induced mood disorder
F14250	Cocaine depend w cocaine-induc psych disorder w delusions	Cocaine dependence with cocaine-induced psychotic disorder with delusions
F14251	Cocaine depend w cocaine-induc psychotic disorder w hallucin	Cocaine dependence with cocaine-induced psychotic disorder with hallucinations
F14259	Cocaine dependence w cocaine-induc psychotic disorder, unsp	Cocaine dependence with cocaine-induced psychotic disorder, unspecified
F14280	Cocaine dependence with cocaine-induced anxiety disorder	Cocaine dependence with cocaine-induced anxiety disorder
F14281	Cocaine dependence with cocaine-induced sexual dysfunction	Cocaine dependence with cocaine-induced sexual dysfunction
F14282	Cocaine dependence with cocaine-induced sleep disorder	Cocaine dependence with cocaine-induced sleep disorder
F14288	Cocaine dependence with other cocaine-induced disorder	Cocaine dependence with other cocaine-induced disorder
	Cocaine dependence with unspecified	
F1429	cocaine-induced disorder	Cocaine dependence with unspecified cocaine-induced disorder
F1490	Cocaine use, unspecified, uncomplicated	Cocaine use, unspecified, uncomplicated
F14920	Cocaine use, unspecified with intoxication, uncomplicated	Cocaine use, unspecified with intoxication, uncomplicated

ICD-CM-10	Short Description	Long Description
	Cocaine use, unspecified with intoxication	
F14921	delirium	Cocaine use, unspecified with intoxication delirium
	Cocaine use, unsp w intoxication with	Cocaine use, unspecified with intoxication with perceptual
F14922	perceptual disturbance	disturbance
	Cocaine use, unspecified with intoxication,	
F14929	unspecified	Cocaine use, unspecified with intoxication, unspecified
F1493	Cocaine use, unspecified with withdrawal	Cocaine use, unspecified with withdrawal
	Cocaine use, unspecified with cocaine-	
F1494	induced mood disorder	Cocaine use, unspecified with cocaine-induced mood disorder
E440E0	Cocaine use, unsp w cocaine-induc psych	Cocaine use, unspecified with cocaine-induced psychotic disorder
F14950	disorder w delusions	with delusions
E140E1	Cocaine use, unsp w cocaine-induc psych	Cocaine use, unspecified with cocaine-induced psychotic disorder
F14951	disorder w hallucin	with hallucinations
F14959	Cocaine use, unsp w cocaine-induced psychotic disorder, unsp	Cocaine use, unspecified with cocaine-induced psychotic disorder, unspecified
F 14909	Cocaine use, unsp with cocaine-induced	unspecified
F14980	anxiety disorder	Cocaine use, unspecified with cocaine-induced anxiety disorder
1 14300	Cocaine use, unsp with cocaine-induced	Cocame ase, anspectice with cocame induced anxiety disorder
F14981	sexual dysfunction	Cocaine use, unspecified with cocaine-induced sexual dysfunction
1 1 100 1	Cocaine use, unspecified with cocaine-	Codanie doc, anoposinou mai occanio madoca coxadi aj cianoloni
F14982	induced sleep disorder	Cocaine use, unspecified with cocaine-induced sleep disorder
	Cocaine use, unspecified with other	
F14988	cocaine-induced disorder	Cocaine use, unspecified with other cocaine-induced disorder
	Cocaine use, unsp with unspecified	Cocaine use, unspecified with unspecified cocaine-induced
F1499	cocaine-induced disorder	disorder
F1510	Other stimulant abuse, uncomplicated	Other stimulant abuse, uncomplicated
	Other stimulant abuse with intoxication,	
F15120	uncomplicated	Other stimulant abuse with intoxication, uncomplicated
	Other stimulant abuse with intoxication	
F15121	delirium	Other stimulant abuse with intoxication delirium
	Oth stimulant abuse w intoxication w	
F15122	perceptual disturbance	Other stimulant abuse with intoxication with perceptual disturbance
E45400	Other stimulant abuse with intoxication,	
F15129	unspecified	Other stimulant abuse with intoxication, unspecified
F1513	Other stimulant abuse with withdrawal	Other stimulant abuse with withdrawal
=1=11	Other stimulant abuse with stimulant-	
F1514	induced mood disorder	Other stimulant abuse with stimulant-induced mood disorder
T15150	Oth stimulant abuse w stim-induce psych	Other stimulant abuse with stimulant-induced psychotic disorder
F15150	disorder w delusions	with delusions Other stigulant physical with stigulant indused payabetic disorder.
F15151	Oth stimulant abuse w stim-induce psych disorder w hallucin	Other stimulant abuse with stimulant-induced psychotic disorder with hallucinations
1 13131	disorder w Handcill	With HalldChiations
	Oth stimulant abuse w stim-induce	Other etimulant abuse with etimulant induced neveloptic discarder
F15159	psychotic disorder, unsp	Other stimulant abuse with stimulant-induced psychotic disorder, unspecified
1 10100	Oth stimulant abuse with stimulant-induced	инареонией
F15180	anxiety disorder	Other stimulant abuse with stimulant-induced anxiety disorder
1 10 100	Oth stimulant abuse w stimulant-induced	Saisi Saimalant abass with stimulant indused anxiety disorder
F15181	sexual dysfunction	Other stimulant abuse with stimulant-induced sexual dysfunction
	Other stimulant abuse with stimulant-	Carte Carried a Capacitation of the Carried Carried Carried Capacitation of Carried Ca
F15182	induced sleep disorder	Other stimulant abuse with stimulant-induced sleep disorder
	Other stimulant abuse with other stimulant-	
F15188	induced disorder	Other stimulant abuse with other stimulant-induced disorder
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ICD-CM-10	Short Description	Long Description
	Other stimulant abuse with unsp stimulant-	
F1519	induced disorder	Other stimulant abuse with unspecified stimulant-induced disorder
	Other stimulant dependence,	
F1520	uncomplicated	Other stimulant dependence, uncomplicated
F1521	Other stimulant dependence, in remission	Other stimulant dependence, in remission
	Other stimulant dependence with	
F15220	intoxication, uncomplicated	Other stimulant dependence with intoxication, uncomplicated
	Other stimulant dependence with	
F15221	intoxication delirium	Other stimulant dependence with intoxication delirium
	Oth stimulant dependence w intox w	Other stimulant dependence with intoxication with perceptual
F15222	perceptual disturbance	disturbance
	Other stimulant dependence with	
F15229	intoxication, unspecified	Other stimulant dependence with intoxication, unspecified
	Other stimulant dependence with	
F1523	withdrawal	Other stimulant dependence with withdrawal
	Oth stimulant dependence w stimulant-	
F1524	induced mood disorder	Other stimulant dependence with stimulant-induced mood disorder
E45050	Oth stim depend w stim-induce psych	Other stimulant dependence with stimulant-induced psychotic
F15250	disorder w delusions	disorder with delusions
=1=0=1	Oth stimulant depend w stim-induce psych	Other stimulant dependence with stimulant-induced psychotic
F15251	disorder w hallucin	disorder with hallucinations
E45050	Oth stimulant depend w stim-induce	Other stimulant dependence with stimulant-induced psychotic
F15259	psychotic disorder, unsp	disorder, unspecified
E45000	Oth stimulant dependence w stim-induce	Other stimulant dependence with stimulant-induced anxiety
F15280	anxiety disorder	disorder
E45004	Oth stimulant dependence w stim-induce	Other stimulant dependence with stimulant-induced sexual
F15281	sexual dysfunction	dysfunction
E45000	Oth stimulant dependence w stimulant-	
F15282	induced sleep disorder	Other stimulant dependence with stimulant-induced sleep disorder
E4E000	Oth stimulant dependence with oth	
F15288	stimulant-induced disorder	Other stimulant dependence with other stimulant-induced disorder
E4E00	Oth stimulant dependence w unsp	Other stimulant dependence with unspecified stimulant-induced
F1529	stimulant-induced disorder	disorder
T1500	Other stimulant use, unspecified,	Other stimulant use unenscified unespecificated
F1590	uncomplicated	Other stimulant use, unspecified, uncomplicated
E4E000	Other stimulant use, unsp with intoxication,	
F15920	uncomplicated	Other stimulant use, unspecified with intoxication, uncomplicated
E15021	Other stimulant use, unspecified with intoxication delirium	Other etimulant use unangeified with intervigation delirium
F15921		Other stimulant use, unspecified with intoxication delirium
F15922	Oth stimulant use, unsp w intox w	Other stimulant use, unspecified with intoxication with perceptual disturbance
F 10922	Perceptual disturbance	disturbance
F15929	Other stimulant use, unsp with intoxication,	Other etimulant use unenceified with interiorities unenceified
1.10978	Unspecified Other stimulant use unspecified with	Other stimulant use, unspecified with intoxication, unspecified
E1502	Other stimulant use, unspecified with withdrawal	Other etimulant use upenseified with withdrawel
F1593	Oth stimulant use, unsp with stimulant-	Other stimulant use, unspecified with withdrawal Other stimulant use, unspecified with stimulant-induced mood
F1594	induced mood disorder	disorder
1 1004	Oth stim use, unsp w stim-induce psych	Other stimulant use, unspecified with stimulant-induced psychotic
F15950	disorder w delusions	disorder with delusions
1 10300		Other stimulant use, unspecified with stimulant-induced psychotic
F15951	Oth stim use, unsp w stim-induce psych disorder w hallucin	disorder with hallucinations
1.19991		
F15959	Oth stimulant use, unsp w stim-induce	Other stimulant use, unspecified with stimulant-induced psychotic disorder, unspecified
1 10303	psych disorder, unsp	Lalsolaet, allspecified

ICD-CM-10	Short Description	Long Description
	Oth stimulant use, unsp w stimulant-	Other stimulant use, unspecified with stimulant-induced anxiety
F15980	induced anxiety disorder	disorder
	Oth stimulant use, unsp w stim-induce	Other stimulant use, unspecified with stimulant-induced sexual
F15981	sexual dysfunction	dysfunction
_,	Oth stimulant use, unsp w stimulant-	Other stimulant use, unspecified with stimulant-induced sleep
F15982	induced sleep disorder	disorder
E45000	Oth stimulant use, unsp with oth stimulant-	Other stimulant use, unspecified with other stimulant-induced
F15988	induced disorder	Other stimulant use unerseified with unerseified etimulant
F1599	Oth stimulant use, unsp with unsp stimulant-induced disorder	Other stimulant use, unspecified with unspecified stimulant-induced disorder
F1610	Hallucinogen abuse, uncomplicated	Hallucinogen abuse, uncomplicated
F16120	Hallucinogen abuse with intoxication,	Hally sing can abuse with interiogistic augustated
F 10 12 U	uncomplicated Hallucinogen abuse with intoxication with	Hallucinogen abuse with intoxication, uncomplicated
F16121	delirium	Hallucinogen abuse with intoxication with delirium
1 10121	Hallucinogen abuse w intoxication w	Tranucinogen abuse with intoxication with definitin
F16122	perceptual disturbance	Hallucinogen abuse with intoxication with perceptual disturbance
	Hallucinogen abuse with intoxication,	Trainedinegeri ababe mai interacation mai perceptaan aletarbanee
F16129	unspecified	Hallucinogen abuse with intoxication, unspecified
	Hallucinogen abuse with hallucinogen-	, ,
F1614	induced mood disorder	Hallucinogen abuse with hallucinogen-induced mood disorder
	Hallucinogen abuse w psychotic disorder w	Hallucinogen abuse with hallucinogen-induced psychotic disorder
F16150	delusions	with delusions
	Hallucinogen abuse w psychotic disorder w	Hallucinogen abuse with hallucinogen-induced psychotic disorder
F16151	hallucinations	with hallucinations
E40450	Hallucinogen abuse w psychotic disorder,	Hallucinogen abuse with hallucinogen-induced psychotic disorder,
F16159	unsp	unspecified
F16180	Hallucinogen abuse w hallucinogen- induced anxiety disorder	Hallucinogen abuse with hallucinogen-induced anxiety disorder
1 10 100	Hallucign abuse w hallucign persisting	Hallucinogen abuse with hallucinogen persisting perception
F16183	perception disorder	disorder (flashbacks)
1 10100	Hallucinogen abuse with other	disorder (hashbashe)
F16188	hallucinogen-induced disorder	Hallucinogen abuse with other hallucinogen-induced disorder
	Hallucinogen abuse with unsp	Hallucinogen abuse with unspecified hallucinogen-induced
F1619	hallucinogen-induced disorder	disorder
F1620	Hallucinogen dependence, uncomplicated	Hallucinogen dependence, uncomplicated
F1621	Hallucinogen dependence, in remission	Hallucinogen dependence, in remission
1 1021	Hallucinogen dependence with	Transonogen acpendence, in remission
F16220	intoxication, uncomplicated	Hallucinogen dependence with intoxication, uncomplicated
	Hallucinogen dependence with intoxication	
F16221	with delirium	Hallucinogen dependence with intoxication with delirium
	Hallucinogen dependence with	
F16229	intoxication, unspecified	Hallucinogen dependence with intoxication, unspecified
	Hallucinogen dependence w hallucinogen-	Hallucinogen dependence with hallucinogen-induced mood
F1624	induced mood disorder	disorder
E100=0	Hallucinogen dependence w psychotic	Hallucinogen dependence with hallucinogen-induced psychotic
F16250	disorder w delusions	disorder with delusions
E400E4	Hallucinogen dependence w psychotic	Hallucinogen dependence with hallucinogen-induced psychotic
F16251	disorder w hallucin	disorder with hallucinations
	Hallucinogen dependence w psychotic	Hallucinogen dependence with hallucinogen-induced psychotic
F16259	disorder, unsp	disorder, unspecified

ICD-CM-10	Short Description	Long Description
	Hallucinogen dependence w anxiety	Hallucinogen dependence with hallucinogen-induced anxiety
F16280	disorder	disorder
	Hallucign depend w hallucign persisting	Hallucinogen dependence with hallucinogen persisting perception
F16283	perception disorder	disorder (flashbacks)
	Hallucinogen dependence w oth	Hallucinogen dependence with other hallucinogen-induced
F16288	hallucinogen-induced disorder	disorder
	Hallucinogen dependence w unsp	Hallucinogen dependence with unspecified hallucinogen-induced
F1629	hallucinogen-induced disorder	disorder
	Hallucinogen use, unspecified,	
F1690	uncomplicated	Hallucinogen use, unspecified, uncomplicated
E40000	Hallucinogen use, unsp with intoxication,	
F16920	uncomplicated	Hallucinogen use, unspecified with intoxication, uncomplicated
E40004	Hallucinogen use, unsp with intoxication	
F16921	with delirium	Hallucinogen use, unspecified with intoxication with delirium
F16929	Hallucinogen use, unspecified with intoxication, unspecified	Hally singer and unaposition with intervigation unaposition
F 10929	Hallucinogen use, unsp w hallucinogen-	Hallucinogen use, unspecified with intoxication, unspecified Hallucinogen use, unspecified with hallucinogen-induced mood
F1694	induced mood disorder	disorder
1 1034	Hallucinogen use, unsp w psychotic	Hallucinogen use, unspecified with hallucinogen-induced psychotic
F16950	disorder w delusions	disorder with delusions
1 10300	Hallucinogen use, unsp w psychotic	Hallucinogen use, unspecified with hallucinogen-induced psychotic
F16951	disorder w hallucinations	disorder with hallucinations
1 10001	Hallucinogen use, unsp w psychotic	Hallucinogen use, unspecified with hallucinogen-induced psychotic
F16959	disorder, unsp	disorder, unspecified
1 10000	alcordor, allop	Hallucinogen use, unspecified with hallucinogen-induced anxiety
F16980	Hallucinogen use, unsp w anxiety disorder	disorder
	Hallucign use, unsp w hallucign persist	Hallucinogen use, unspecified with hallucinogen persisting
F16983	perception disorder	perception disorder (flashbacks)
	Hallucinogen use, unsp w oth	Hallucinogen use, unspecified with other hallucinogen-induced
F16988	hallucinogen-induced disorder	disorder
	Hallucinogen use, unsp w unsp	Hallucinogen use, unspecified with unspecified hallucinogen-
F1699	hallucinogen-induced disorder	induced disorder
F1810	Inhalant abuse, uncomplicated	Inhalant abuse, uncomplicated
	Inhalant abuse with intoxication,	
F18120	uncomplicated	Inhalant abuse with intoxication, uncomplicated
F18121	Inhalant abuse with intoxication delirium	Inhalant abuse with intoxication delirium
	Inhalant abuse with intoxication,	
F18129	unspecified	Inhalant abuse with intoxication, unspecified
	Inhalant abuse with inhalant-induced mood	, ,
F1814	disorder	Inhalant abuse with inhalant-induced mood disorder
	Inhalant abuse w inhalnt-induce psych	Inhalant abuse with inhalant-induced psychotic disorder with
F18150	disorder w delusions	delusions
	Inhalant abuse w inhalnt-induce psych	Inhalant abuse with inhalant-induced psychotic disorder with
F18151	disorder w hallucin	hallucinations
	Inhalant abuse w inhalant-induced	Inhalant abuse with inhalant-induced psychotic disorder,
F18159	psychotic disorder, unsp	unspecified
	Inhalant abuse with inhalant-induced	
F1817	dementia	Inhalant abuse with inhalant-induced dementia
E40400	Inhalant abuse with inhalant-induced	
F18180	anxiety disorder	Inhalant abuse with inhalant-induced anxiety disorder
	Inhalant abuse with other inhalant-induced	
F18188	disorder	Inhalant abuse with other inhalant-induced disorder
. 10100	aiooraor	I initializate abase with state initializate induced disorder

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ICD-CM-10	Short Description	Long Description
	Inhalant abuse with unspecified inhalant-	<u> </u>
F1819	induced disorder	Inhalant abuse with unspecified inhalant-induced disorder
F1820	Inhalant dependence, uncomplicated	Inhalant dependence, uncomplicated
F1821	Inhalant dependence, in remission	Inhalant dependence, in remission
	Inhalant dependence with intoxication,	
F18220	uncomplicated	Inhalant dependence with intoxication, uncomplicated
	Inhalant dependence with intoxication	
F18221	delirium	Inhalant dependence with intoxication delirium
F18229	Inhalant dependence with intoxication, unspecified	Inhalant danandanaa with intervigation, unanacified
F 10229	Inhalant dependence with inhalant-induced	Inhalant dependence with intoxication, unspecified
F1824	mood disorder	Inhalant dependence with inhalant-induced mood disorder
02.	Inhalant depend w inhalnt-induce psych	Inhalant dependence with inhalant-induced psychotic disorder with
F18250	disorder w delusions	delusions
. 10200	Inhalant depend w inhalnt-induce psych	Inhalant dependence with inhalant-induced psychotic disorder with
F18251	disorder w hallucin	hallucinations
	Inhalant depend w inhalnt-induce psychotic	Inhalant dependence with inhalant-induced psychotic disorder,
F18259	disorder, unsp	unspecified
	Inhalant dependence with inhalant-induced	
F1827	dementia	Inhalant dependence with inhalant-induced dementia
F18280	Inhalant dependence with inhalant-induced	Inhalant danandanaa with inhalant induaad anviatu diaardar
F 1020U	anxiety disorder Inhalant dependence with other inhalant-	Inhalant dependence with inhalant-induced anxiety disorder
F18288	induced disorder	Inhalant dependence with other inhalant-induced disorder
1 10200	Inhalant dependence with unsp inhalant-	mindant depondence with other mindant medeced decider
F1829	induced disorder	Inhalant dependence with unspecified inhalant-induced disorder
F1890	Inhalant use, unspecified, uncomplicated	Inhalant use, unspecified, uncomplicated
	Inhalant use, unspecified with intoxication,	, , , , , , , , , , , , , , , , , , , ,
F18920	uncomplicated	Inhalant use, unspecified with intoxication, uncomplicated
	Inhalant use, unspecified with intoxication	
F18921	with delirium	Inhalant use, unspecified with intoxication with delirium
E40000	Inhalant use, unspecified with intoxication,	
F18929	unspecified Inhalant use, unsp with inhalant-induced	Inhalant use, unspecified with intoxication, unspecified
F1894	mood disorder	Inhalant use, unspecified with inhalant-induced mood disorder
1 100 1	Inhalant use, unsp w inhalnt-induce psych	Inhalant use, unspecified with inhalant-induced psychotic disorder
F18950	disord w delusions	with delusions
	Inhalant use, unsp w inhalnt-induce psych	Inhalant use, unspecified with inhalant-induced psychotic disorder
F18951	disord w hallucin	with hallucinations
	Inhalant use, unsp w inhalnt-induce	Inhalant use, unspecified with inhalant-induced psychotic disorder,
F18959	psychotic disorder, unsp	unspecified
	Inhalant use, unsp with inhalant-induced	Inhalant use, unspecified with inhalant-induced persisting
F1897	persisting dementia	dementia
	Inhalant use, unsp with inhalant-induced	
F18980	anxiety disorder	Inhalant use, unspecified with inhalant-induced anxiety disorder
E10000	Inhalant use, unsp with other inhalant-	
F18988	induced disorder	Inhalant use, unspecified with other inhalant-induced disorder
E1000	Inhalant use, unsp with unsp inhalant-	Inhalant use, unspecified with unspecified inhalant-induced
F1899	induced disorder	disorder
F1910	Other psychoactive substance abuse, uncomplicated	Other psychoactive substance abuse, uncomplicated
1 10 10	uncomplicated	Other payorioactive aubatarice abuse, uncomplicated

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ICD-CM-10	Short Description	Long Description
	Oth psychoactive substance abuse w	Other psychoactive substance abuse with intoxication,
F19120	intoxication, uncomp	uncomplicated
	Oth psychoactive substance abuse with	
F19121	intoxication delirium	Other psychoactive substance abuse with intoxication delirium
	Oth psychoactv substance abuse w intox w	Other psychoactive substance abuse with intoxication with
F19122	perceptual disturb	perceptual disturbances
	Other psychoactive substance abuse with	
F19129	intoxication, unsp	Other psychoactive substance abuse with intoxication, unspecified
	Other psychoactive substance abuse with	Other psychoactive substance abuse with withdrawal,
F19130	withdrawal, uncomplicated	uncomplicated
	Other psychoactive substance abuse with	
F19131	withdrawal delirium	Other psychoactive substance abuse with withdrawal delirium
	Sedative, hypnotic or anxiolytic abuse with	Sedative, hypnotic or anxiolytic abuse with withdrawal with
F19132	withdrawal with perceptual disturbance	perceptual disturbance
	Sedative, hypnotic or anxiolytic abuse with	
F19139	withdrawal, unspecified	Sedative, hypnotic or anxiolytic abuse with withdrawal, unspecified
	Oth psychoactive substance abuse w	Other psychoactive substance abuse with psychoactive
F1914	mood disorder	substance-induced mood disorder
	Oth psychoactv substance abuse w psych	Other psychoactive substance abuse with psychoactive
F19150	disorder w delusions	substance-induced psychotic disorder with delusions
	Oth psychoactv substance abuse w psych	Other psychoactive substance abuse with psychoactive
F19151	disorder w hallucin	substance-induced psychotic disorder with hallucinations
	Oth psychoactive substance abuse w	Other psychoactive substance abuse with psychoactive
F19159	psychotic disorder, unsp	substance-induced psychotic disorder, unspecified
	Oth psychoactv substance abuse w persist	Other psychoactive substance abuse with psychoactive
F1916	amnestic disorder	substance-induced persisting amnestic disorder
	Oth psychoactive substance abuse w	Other psychoactive substance abuse with psychoactive
F1917	persisting dementia	substance-induced persisting dementia
-	Oth psychoactive substance abuse w	Other psychoactive substance abuse with psychoactive
F19180	anxiety disorder	substance-induced anxiety disorder
	Oth psychoactive substance abuse w	Other psychoactive substance abuse with psychoactive
F19181	sexual dysfunction	substance-induced sexual dysfunction
	Oth psychoactive substance abuse w	Other psychoactive substance abuse with psychoactive
F19182	sleep disorder	substance-induced sleep disorder
	Oth psychoactive substance abuse w oth	Other psychoactive substance abuse with other psychoactive
F19188	disorder	substance-induced disorder
	Oth psychoactive substance abuse w unsp	Other psychoactive substance abuse with unspecified
F1919	disorder	psychoactive substance-induced disorder
	Other psychoactive substance	
F1920	dependence, uncomplicated	Other psychoactive substance dependence, uncomplicated
	Other psychoactive substance	
F1921	dependence, in remission	Other psychoactive substance dependence, in remission
	Oth psychoactive substance dependence	Other psychoactive substance dependence with intoxication,
F19220	w intoxication, uncomp	uncomplicated
	Oth psychoactive substance dependence	Other psychoactive substance dependence with intoxication
F19221	w intox delirium	delirium
	Oth psychoactv substance depend w intox	Other psychoactive substance dependence with intoxication with
F19222	w perceptual disturb	perceptual disturbance
	Oth psychoactive substance dependence	Other psychoactive substance dependence with intoxication,
F19229	w intoxication, unsp	unspecified
1 13223		
1 13223	Oth psychoactive substance dependence	Other psychoactive substance dependence with withdrawal,

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ICD-CM-10	Short Description	Long Description
	Oth psychoactive substance dependence	Other psychoactive substance dependence with withdrawal
F19231	w withdrawal delirium	delirium
	Oth psychoactv sub depend w w/drawal w	Other psychoactive substance dependence with withdrawal with
F19232	perceptl disturb	perceptual disturbance
	Oth psychoactive substance dependence	Other psychoactive substance dependence with withdrawal,
F19239	with withdrawal, unsp	unspecified
	Oth psychoactive substance dependence	Other psychoactive substance dependence with psychoactive
F1924	w mood disorder	substance-induced mood disorder
	Oth psychoactv substance depend w	Other psychoactive substance dependence with psychoactive
F19250	psych disorder w delusions	substance-induced psychotic disorder with delusions
	Oth psychoactv substance depend w	Other psychoactive substance dependence with psychoactive
F19251	psych disorder w hallucin	substance-induced psychotic disorder with hallucinations
	Oth psychoactv substance depend w	Other psychoactive substance dependence with psychoactive
F19259	psychotic disorder, unsp	substance-induced psychotic disorder, unspecified
	Oth psychoactv substance depend w	Other psychoactive substance dependence with psychoactive
F1926	persist amnestic disorder	substance-induced persisting amnestic disorder
	Oth psychoactive substance dependence	Other psychoactive substance dependence with psychoactive
F1927	w persisting dementia	substance-induced persisting dementia
	Oth psychoactive substance dependence	Other psychoactive substance dependence with psychoactive
F19280	w anxiety disorder	substance-induced anxiety disorder
	Oth psychoactive substance dependence	Other psychoactive substance dependence with psychoactive
F19281	w sexual dysfunction	substance-induced sexual dysfunction
	Oth psychoactive substance dependence	Other psychoactive substance dependence with psychoactive
F19282	w sleep disorder	substance-induced sleep disorder
	Oth psychoactive substance dependence	Other psychoactive substance dependence with other
F19288	w oth disorder	psychoactive substance-induced disorder
	Oth psychoactive substance dependence	Other psychoactive substance dependence with unspecified
F1929	w unsp disorder	psychoactive substance-induced disorder
	Other psychoactive substance use,	
F1990	unspecified, uncomplicated	Other psychoactive substance use, unspecified, uncomplicated
_,,,,,,	Oth psychoactive substance use, unsp w	Other psychoactive substance use, unspecified with intoxication
F19920	intoxication, uncomp	uncomplicated
	Oth psychoactive substance use, unsp w	Other psychoactive substance use, unspecified with intoxication
F19921	intox w delirium	with delirium
	Oth psychoactv sub use, unsp w intox w	Other psychoactive substance use, unspecified with intoxication
F19922	perceptl disturb	with perceptual disturbance
- 40005	Oth psychoactive substance use, unsp	Other psychoactive substance use, unspecified with intoxication
F19929	with intoxication, unsp	unspecified
=1000	Oth psychoactive substance use, unsp w	Other psychoactive substance use, unspecified with withdrawal,
F19930	withdrawal, uncomp	uncomplicated
E40004	Oth psychoactive substance use, unsp w	Other psychoactive substance use, unspecified with withdrawal
F19931	withdrawal delirium	delirium
E40000	Oth psychoactv sub use, unsp w w/drawal	Other psychoactive substance use, unspecified with withdrawal
F19932	w perceptl disturb	with perceptual disturbance
E40000	Other psychoactive substance use, unsp	Other psychoactive substance use, unspecified with withdrawal,
F19939	with withdrawal, unsp	unspecified
	Oth psychoactive substance use, unsp w	Other psychoactive substance use, unspecified with psychoactiv
F1994	mood disorder	substance-induced mood disorder
E400=0	Oth psychoactv sub use, unsp w psych	Other psychoactive substance use, unspecified with psychoactive
F19950	disorder w delusions	substance-induced psychotic disorder with delusions
=400=4	Oth psychoactv sub use, unsp w psych	Other psychoactive substance use, unspecified with psychoactive
F19951	disorder w hallucin	substance-induced psychotic disorder with hallucinations

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ICD-CM-10	Short Description	Long Description
	Oth psychoactv substance use, unsp w	Other psychoactive substance use, unspecified with psychoactive
F19959	psych disorder, unsp	substance-induced psychotic disorder, unspecified
	Oth psychoactv sub use, unsp w persist	Other psychoactive substance use, unspecified with psychoactive
F1996	amnestic disorder	substance-induced persisting amnestic disorder
F1997	Oth psychoactive substance use, unsp w	Other psychoactive substance use, unspecified with psychoactive
F 1991	persisting dementia Oth psychoactive substance use, unsp w	substance-induced persisting dementia Other psychoactive substance use, unspecified with psychoactive
F19980	anxiety disorder	substance-induced anxiety disorder
1 10000	Oth psychoactive substance use, unsp w	Other psychoactive substance use, unspecified with psychoactive
F19981	sexual dysfunction	substance-induced sexual dysfunction
	Oth psychoactive substance use, unsp w	Other psychoactive substance use, unspecified with psychoactive
F19982	sleep disorder	substance-induced sleep disorder
- 40000	Oth psychoactive substance use, unsp w	Other psychoactive substance use, unspecified with other
F19988	oth disorder	psychoactive substance-induced disorder
F1999	Oth psychoactive substance use, unsp w unsp disorder	Other psychoactive substance use, unspecified with unspecified psychoactive substance-induced disorder
	' ·	
F200	Paranoid schizophrenia	Paranoid schizophrenia
F201	Disorganized schizophrenia	Disorganized schizophrenia
F202	Catatonic schizophrenia	Catatonic schizophrenia
F203	Undifferentiated schizophrenia	Undifferentiated schizophrenia
F205	Residual schizophrenia	Residual schizophrenia
F2081	Schizophreniform disorder	Schizophreniform disorder
F2089	Other schizophrenia	Other schizophrenia
F209	Schizophrenia, unspecified	Schizophrenia, unspecified
F21	Schizotypal disorder	Schizotypal disorder
F22	Delusional disorders	Delusional disorders
F23	Brief psychotic disorder	Brief psychotic disorder
F24	Shared psychotic disorder	Shared psychotic disorder
F250	Schizoaffective disorder, bipolar type	Schizoaffective disorder, bipolar type
F251	Schizoaffective disorder, depressive type	Schizoaffective disorder, depressive type
F258	Other schizoaffective disorders	Other schizoaffective disorders
F259	Schizoaffective disorder, unspecified	Schizoaffective disorder, unspecified
	Oth psych disorder not due to a sub or	Other psychotic disorder not due to a substance or known
F28	known physiol cond	physiological condition
F00	Unsp psychosis not due to a substance or	Unspecified psychosis not due to a substance or known
F29	known physiol cond	physiological condition
F3010	Manic episode without psychotic symptoms, unspecified	Manic episode without psychotic symptoms, unspecified
1 00 10	Manic episode without psychotic	Wallo opioodo Wallout poyoriotto symptomo, anoposinod
F3011	symptoms, mild	Manic episode without psychotic symptoms, mild
	Manic episode without psychotic	
F3012	symptoms, moderate	Manic episode without psychotic symptoms, moderate
E0040	Manic episode, severe, without psychotic	M
F3013	symptoms Mania anianda, aquara with navahatia	Manic episode, severe, without psychotic symptoms
F302	Manic episode, severe with psychotic symptoms	Manic episode, severe with psychotic symptoms
F303		
	Manic episode in partial remission	Manic episode in partial remission
F304	Manic episode in full remission Manic episode in full remission	

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ICD-CM-10	Short Description	Long Description	
F308	Other manic episodes	Other manic episodes	
F309	Manic episode, unspecified	Manic episode, unspecified	
	Bipolar disorder, current episode		
F310	hypomanic	Bipolar disorder, current episode hypomanic	
	Bipolar disord, crnt episode manic w/o	Bipolar disorder, current episode manic without psychotic features,	
F3110	psych features, unsp	unspecified	
	Bipolar disord, crnt episode manic w/o	Bipolar disorder, current episode manic without psychotic features,	
F3111	psych features, mild	mild	
50440	Bipolar disord, crnt episode manic w/o	Bipolar disorder, current episode manic without psychotic features,	
F3112	psych features, mod	moderate	
E2112	Bipolar disord, crnt epsd manic w/o psych	Bipolar disorder, current episode manic without psychotic features,	
F3113	features, severe Bipolar disord, crnt episode manic severe	Severe Bipolar disorder, current episode manic severe with psychotic	
F312	w psych features	features	
1312	Bipolar disord, crnt epsd depress, mild or	Bipolar disorder, current episode depressed, mild or moderate	
F3130	mod severt, unsp	severity, unspecified	
	Bipolar disorder, current episode		
F3131	depressed, mild	Bipolar disorder, current episode depressed, mild	
	Bipolar disorder, current episode		
F3132	depressed, moderate	Bipolar disorder, current episode depressed, moderate	
	Bipolar disord, crnt epsd depress, sev, w/o	Bipolar disorder, current episode depressed, severe, without	
F314	psych features	psychotic features	
	Bipolar disord, crnt epsd depress, severe,	Bipolar disorder, current episode depressed, severe, with	
F315	w psych features	psychotic features	
F2460	Bipolar disorder, current episode mixed,	Dinalar disarder, surrent enjects mixed unensaified	
F3160	unspecified	Bipolar disorder, current episode mixed, unspecified	
F3161	Bipolar disorder, current episode mixed, mild	Bipolar disorder, current episode mixed, mild	
1 3 1 0 1	Bipolar disorder, current episode mixed,	bipolal disorder, current episode mixed, mild	
F3162	moderate	Bipolar disorder, current episode mixed, moderate	
E2462	Bipolar disord, crnt epsd mixed, severe,	Bipolar disorder, current episode mixed, severe, without psychotic	
F3163	W/o psych features	features Display disorder autrent enicode mixed acycles with nevel to	
F3164	Bipolar disord, crnt episode mixed, severe, w psych features	Bipolar disorder, current episode mixed, severe, with psychotic features	
1 3 104	Bipolar disord, currently in remis, most	Bipolar disorder, currently in remission, most recent episode	
F3170	recent episode unsp	unspecified	
	Bipolar disord, in partial remis, most recent	Bipolar disorder, in partial remission, most recent episode	
F3171	epsd hypomanic	hypomanic	
	Bipolar disord, in full remis, most recent		
F3172	episode hypomanic	Bipolar disorder, in full remission, most recent episode hypomanic	
	Bipolar disord, in partial remis, most recent		
F3173	episode manic	Bipolar disorder, in partial remission, most recent episode manic	
E0474	Bipolar disorder, in full remis, most recent		
F3174	episode manic	Bipolar disorder, in full remission, most recent episode manic	
E2175	Bipolar disord, in partial remis, most recent	Bipolar disorder, in partial remission, most recent episode	
F3175	epsd depress Bipolar disorder, in full remis, most recent	depressed	
F3176	episode depress	Bipolar disorder, in full remission, most recent episode depressed	
	Bipolar disord, in partial remis, most recent	Dipolal divordor, in fail formission, most recent episode deplessed	
F3177	episode mixed	Bipolar disorder, in partial remission, most recent episode mixed	
	Bipolar disorder, in full remis, most recent	, , , , , , , , , , , , , , , , , , , ,	
F3178	episode mixed	Bipolar disorder, in full remission, most recent episode mixed	

ICD-CM-10	Short Description	Long Description	
F3181	Bipolar II disorder	Bipolar II disorder	
F3189	Other bipolar disorder	Other bipolar disorder	
F319	Bipolar disorder, unspecified	Bipolar disorder, unspecified	
F320	Major depressive disorder, single episode, mild	Major depressive disorder, single episode, mild	
1 320	Major depressive disorder, single episode,	major depressive disorder, single episode, mild	
F321	moderate	Major depressive disorder, single episode, moderate	
F322	Major depressv disord, single epsd, sev w/o psych features	Major depressive disorder, single episode, severe without psychotic features	
F323	Major depressv disord, single epsd, severe w psych features	Major depressive disorder, single episode, severe with psychotic features	
F324	Major depressv disorder, single episode, in partial remis	Major depressive disorder, single episode, in partial remission	
F325	Major depressive disorder, single episode, in full remission	Major depressive disorder, single episode, in full remission	
F328	Other depressive episodes	Other depressive episodes	
F329	Major depressive disorder, single episode, unspecified	Major depressive disorder, single episode, unspecified	
F330	Major depressive disorder, recurrent, mild	Major depressive disorder, recurrent, mild	
E004	Major depressive disorder, recurrent,		
F331	moderate Major depressy disorder, recurrent severe	Major depressive disorder, recurrent, moderate Major depressive disorder, recurrent severe without psychotic	
F332	w/o psych features	features	
F333	Major depressy disorder, recurrent, severe w psych symptoms		
	Major depressive disorder, recurrent, in		
F3340	remission, unsp Major depressive disorder, recurrent, in	Major depressive disorder, recurrent, in remission, unspecified	
F3341	partial remission	Major depressive disorder, recurrent, in partial remission	
F3342	Major depressive disorder, recurrent, in full remission	Major depressive disorder, recurrent, in full remission	
F338	Other recurrent depressive disorders	Other recurrent depressive disorders	
F339	Major depressive disorder, recurrent, unspecified	Major depressive disorder, recurrent, unspecified	
F340	Cyclothymic disorder	Cyclothymic disorder	
F341	Dysthymic disorder	Dysthymic disorder	
F348	Other persistent mood [affective] disorders	Other persistent mood [affective] disorders	
F349	Persistent mood [affective] disorder, unspecified	Persistent mood [affective] disorder, unspecified	
F39	Unspecified mood [affective] disorder	Unspecified mood [affective] disorder	
F4000	Agoraphobia, unspecified	Agoraphobia, unspecified	
F4001	Agoraphobia with panic disorder	Agoraphobia with panic disorder	
F4002	Agoraphobia without panic disorder	Agoraphobia without panic disorder	
F4010	Social phobia, unspecified	Social phobia, unspecified	
F4011	Social phobia, generalized	Social phobia, generalized	
F40210	Arachnophobia	Arachnophobia	
F40218	Other animal type phobia	Other animal type phobia	
F40220	Fear of thunderstorms	Fear of thunderstorms	
		1	

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ICD-CM-10	Short Description	Long Description	
F40228	Other natural environment type phobia	Other natural environment type phobia	
F40230	Fear of blood	Fear of blood	
F40231	Fear of injections and transfusions	Fear of injections and transfusions	
F40232	Fear of other medical care	Fear of other medical care	
F40233	Fear of injury	Fear of injury	
F40240	Claustrophobia	Claustrophobia	
F40241	Acrophobia	Acrophobia	
F40242	Fear of bridges	Fear of bridges	
F40243	Fear of flying	Fear of flying	
F40248	Other situational type phobia	Other situational type phobia	
F40290	Androphobia	Androphobia	
F40291	Gynephobia	Gynephobia	
F40298	Other specified phobia	Other specified phobia	
F408	Other phobic anxiety disorders	Other phobic anxiety disorders	
F409	Phobic anxiety disorder, unspecified	Phobic anxiety disorder, unspecified	
F410	Panic disorder without agoraphobia	Panic disorder [episodic paroxysmal anxiety] without agoraphobia	
F411	Generalized anxiety disorder	Generalized anxiety disorder	
F413	Other mixed anxiety disorders	Other mixed anxiety disorders	
F418	Other specified anxiety disorders	Other specified anxiety disorders	
F419	Anxiety disorder, unspecified	Anxiety disorder, unspecified	
F42	Obsessive-compulsive disorder	Obsessive-compulsive disorder	
F430	Acute stress reaction	Acute stress reaction	
F4310	Post-traumatic stress disorder, unspecified	Post-traumatic stress disorder, unspecified	
F4311	Post-traumatic stress disorder, acute	Post-traumatic stress disorder, acute	
F4312	Post-traumatic stress disorder, chronic	Post-traumatic stress disorder, chronic	
F4320	Adjustment disorder, unspecified	Adjustment disorder, unspecified	
F4321	Adjustment disorder with depressed mood	Adjustment disorder with depressed mood	
F4322	Adjustment disorder with anxiety	Adjustment disorder with anxiety	
F4323	Adjustment disorder with mixed anxiety and depressed mood	Adjustment disorder with mixed anxiety and depressed mood	
F4324	Adjustment disorder with disturbance of conduct	Adjustment disorder with disturbance of conduct	
F4325	Adjustment disorder w mixed disturb of emotions and conduct	Adjustment disorder with mixed disturbance of emotions and conduct	
F4329	Adjustment disorder with other symptoms	Adjustment disorder with other symptoms	
F438	Other reactions to severe stress	Other reactions to severe stress	
F439	Reaction to severe stress, unspecified	Reaction to severe stress, unspecified	
F440	Dissociative amnesia	Dissociative amnesia	
F441	Dissociative fugue	Dissociative fugue	
F442	Dissociative stupor	Dissociative stupor	
F444	Conversion disorder with motor symptom or deficit	Conversion disorder with motor symptom or deficit	

Short Description	Long Description
·	
Conversion disorder with seizures or	
convulsions	Conversion disorder with seizures or convulsions
	Conversion disorder with sensory symptom or deficit
•	Conversion disorder with mixed symptom presentation
'	Dissociative identity disorder
Other dissociative and conversion	
disorders	Other dissociative and conversion disorders
	Dissociative and conversion disorder, unspecified
urispecified	Dissociative and conversion disorder, unspecified
Somatization disorder	Somatization disorder
Undifferentiated somatoform disorder	Undifferentiated somatoform disorder
Hypochondriacal disorder, unspecified	Hypochondriacal disorder, unspecified
	Hypochondriasis
<u> </u>	Body dysmorphic disorder
 ' ' 	Other hypochondriacal disorders
Pain disorder exclusively related to	, , , , , , , , , , , , , , , , , , ,
psychological factors	Pain disorder exclusively related to psychological factors
	Pain disorder with related psychological factors
10.000	Other somatoform disorders
	Somatoform disorders Somatoform disorder, unspecified
	Depersonalization-derealization syndrome
· ·	Pseudobulbar affect
	rseudobdibai aliect
disorders	Other specified nonpsychotic mental disorders
Nonpsychotic mental disorder, unspecified	Nonpsychotic mental disorder, unspecified
Anorexia nervosa, unspecified	Anorexia nervosa, unspecified
Anorexia nervosa, restricting type	Anorexia nervosa, restricting type
Anorexia nervosa, binge eating/purging	
	Anorexia nervosa, binge eating/purging type
	Bulimia nervosa
	Other eating disorders
	Eating disorder, unspecified
	Puerperal psychosis
	Psychological and behavioral factors associated with disorders or diseases classified elsewhere
	Paranoid personality disorder
i i	Schizoid personality disorder
	Antisocial personality disorder
<u> </u>	Borderline personality disorder
	Histrionic personality disorder
	Obsessive-compulsive personality disorder
Avoidant personality disorder	Avoidant personality disorder
	Conversion disorder with seizures or convulsions Conversion disorder with sensory symptom or deficit Conversion disorder with mixed symptom presentation Dissociative identity disorder Other dissociative and conversion disorders Dissociative and conversion disorder, unspecified Somatization disorder Undifferentiated somatoform disorder Hypochondriacal disorder, unspecified Hypochondriasis Body dysmorphic disorder Other hypochondriacal disorders Pain disorder exclusively related to psychological factors Pain disorder with related psychological factors Other somatoform disorders Somatoform disorder, unspecified Depersonalization-derealization syndrome Pseudobulbar affect Other specified nonpsychotic mental disorders Nonpsychotic mental disorder, unspecified Anorexia nervosa, unspecified Anorexia nervosa, restricting type Anorexia nervosa, binge eating/purging type Bulimia nervosa Other eating disorders Eating disorder, unspecified Puerperal psychosis Psych & behavrl factors assoc w disord or dis classd elswhr Paranoid personality disorder Schizoid personality disorder Schizoid personality disorder Antisocial personality disorder Bristrionic personality disorder Histrionic personality disorder Obsessive-compulsive personality disorder

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ICD-CM-10	Short Description	Long Description	
F607	Dependent personality disorder	Dependent personality disorder	
F6081	Narcissistic personality disorder	Narcissistic personality disorder	
F6089	Other specific personality disorders	Other specific personality disorders	
F609	Personality disorder, unspecified	Personality disorder, unspecified	
F631	Pyromania	Pyromania	
F632	Kleptomania	Kleptomania	
F633	Trichotillomania	Trichotillomania	
F6381	Intermittent explosive disorder	Intermittent explosive disorder	
F6389	Other impulse disorders	Other impulse disorders	
F639	Impulse disorders Impulse disorder, unspecified	Impulse disorder, unspecified	
F641	Gender identity disorder in adolescence and adulthood	Gender identity disorder in adolescence and adulthood	
F642	Gender identity disorder of childhood	Gender identity disorder of childhood	
F648	Other gender identity disorders	Other gender identity disorders	
F649	<u> </u>	<u> </u>	
	Gender identity disorder, unspecified	Gender identity disorder, unspecified	
F6810	Factitious disorder, unspecified Factitious disorder w predom psych signs	Factitious disorder, unspecified Factitious disorder with predominantly psychological signs and	
F6811	and symptoms	symptoms	
	Factitious disorder w predom physical	Factitious disorder with predominantly physical signs and	
F6812	signs and symptoms	symptoms	
E6042	Factitious disord w comb psych and physol	Factitious disorder with combined psychological and physical signs	
F6813	signs and symptoms Other specified disorders of adult	and symptoms	
F688	personality and behavior	Other specified disorders of adult personality and behavior	
F69	Unspecified disorder of adult personality and behavior	Unspecified disorder of adult personality and behavior	
	Other disorders of psychological	The second secon	
F88	development	Other disorders of psychological development	
Ε00	Unspecified disorder of psychological		
F89	development Attn-defct hyperactivity disorder, predom	Unspecified disorder of psychological development Attention-deficit hyperactivity disorder, predominantly inattentive	
F900	inattentive type	type	
	Attn-defct hyperactivity disorder, predom	Attention-deficit hyperactivity disorder, predominantly hyperactive	
F901	hyperactive type	type	
F902	Attention-deficit hyperactivity disorder,	Attention-deficit hyperactivity disorder, combined type	
F90Z	combined type Attention-deficit hyperactivity disorder,	Attention-deficit hyperactivity disorder, combined type	
F908	other type	Attention-deficit hyperactivity disorder, other type	
	Attention-deficit hyperactivity disorder,		
F909	unspecified type	Attention-deficit hyperactivity disorder, unspecified type	
F910	Conduct disorder confined to family context	Conduct disorder confined to family context	
F911	Conduct disorder, childhood-onset type	Conduct disorder, childhood-onset type	
F912	Conduct disorder, adolescent-onset type	Conduct disorder, adolescent-onset type	
F913	Oppositional defiant disorder	Oppositional defiant disorder	
F918	Other conduct disorders	Other conduct disorders	
F910 F919	Conduct disorders Conduct disorder, unspecified	Conduct disorders Conduct disorder, unspecified	
		er of childhood Separation anxiety disorder of childhood	

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ICD-CM-10	Short Description	Long Description
F938	Other childhood emotional disorders	Other childhood emotional disorders
F939	Childhood emotional disorder, unspecified	Childhood emotional disorder, unspecified
F940	Selective mutism	Selective mutism
F941	Reactive attachment disorder of childhood	Reactive attachment disorder of childhood
F942	Disinhibited attachment disorder of childhood	Disinhibited attachment disorder of childhood
F948	Other childhood disorders of social functioning	Other childhood disorders of social functioning
F949	Childhood disorder of social functioning, unspecified	Childhood disorder of social functioning, unspecified
F980	Enuresis not due to a substance or known physiol condition	Enuresis not due to a substance or known physiological condition
F981	Encopresis not due to a substance or known physiol condition	Encopresis not due to a substance or known physiological condition
F988	Oth behav/emotn disord w onset usly occur in chldhd and adol	Other specified behavioral and emotional disorders with onset usually occurring in childhood and adolescence
F989	Unsp behav/emotn disord w onst usly occur in chldhd and adol	Unspecified behavioral and emotional disorders with onset usually occurring in childhood and adolescence
F99	Mental disorder, not otherwise specified	Mental disorder, not otherwise specified

APPENDIX D: CERTIFIED ALCOHOL AND DRUG COUNSELOR-TRAINEE SUPERVISION FORM

	CERTIFIED ALCOHOL AND DRUG COUNSELOR-TRAINEE / COUNSELOR IN	
	TRAINING SUPERVISION FORMIndividual Group	
D·B·H·D·D		

SECTION A. EMPLOYEE INFORMATION			
Name:	Month of Supervision:		
Hire Date as a Certified Alcohol and Drug Counselor-Trainee:	Projected Certification Tes (Eligible to test w/in 2 years of hi		
SECTION B.			
Check Domain discussed during Supervision and brie	fly describe (see TAP 21	I description):	
O Clinical Evaluation (total monthly hours completed	l:) (accumulative ho	urs completed:)	
o Treatment Planning (total monthly hours complete	d:) (accumulative ho	ours completed:)	
o Referral (total monthly hours completed:) (ad	ccumulative hours comple	ted:)	
Service Coordination (total monthly hours complete)	ted:) (accumulative h	nours completed:)	
O Counseling (total monthly hours completed:	(accumulative hours com	pleted:)	
Client, Family and Community Education (total mo completed:)			
O Documentation (total monthly hours completed: _) (accumulative hours	completed:)	
 Professional and Ethical Responsibilities (total mocompleted:) 	' ' ' ' ' ' ' ' ' ' ' ' ' ' ' ' ' ' ' '		
Short Term Goals/Action Required: (define expectations – timelines – areas needing improvement)			
Training Needs: (progress toward certification, licensure and/or other areas of professional growth)			
Training Hours Completed: Next Scheduled Supervision:			
SECTION C. SIGNATURES			
Supervisor's Signature and credentials ¹² :		Date:	
Employee Signature:		Date:	

¹² The following credentials are acceptable for Clinical Supervision and are required to provide proof of credential: CCS; CADC; CCADC; CAC II; MAC or LPC/ LCSW/LMFT who have a minimum of 5 hours of Co-Occurring or Addiction specific Continuing Education hours per year, certification of attendance/completion must be on file.

APPENDIX E: COVID-19 Public Health Emergency: DBHDD Communications to Providers

This Appendix was created to memorialize DBHDD communications to providers regarding service, policy, and procedure modifications that are either allowable (at the provider's discretion) or expected (by the DBHDD) during the COVID-19 Public Health Emergency. The communications contained herein include only those with significant and direct bearing on the content of the Provider Manual for Community Behavioral Health Providers.

The content in this Appendix will be updated periodically during the Public Health Emergency via a "Special Interim Re-Posting" of the Provider Manual and will be labeled as such on the title page. This Appendix will serve as a chronological record of communications and will be added to with each subsequent Special Interim Re-Posting. Although prior content will not be removed, *new* content added to this Appendix in each Special Interim Re-Posting will only reflect communications released during the normal effective dates of this particular Provider Manual.

3/14/2020	Special Bulletin	Message from Commissioner Fitzgerald related to Coronavirus; DBHDD/DCH guidance for IDD and BH Services
03/14/2020	Memorandum	Service Allowances due to COVID-19
03/14/2020 and 3/19/2020	Guidance	Telemed and Telephonic Coverage
03/17/2020	Guidance	ACT and CST guidance for COVID-19
03/17/2020	Guidance	State Opioid Treatment Authority – COVID-19
03/18/2020	Guidance	Apex – COVID-19
03/18/2020	Guidance	BHCC/CSU for COVID-19
03/18/2020	Guidance	DBHDD Addiction Recovery Support Centers/Peer Wellness and Respite Centers
03/19/2020	Guidance	COVID 19 Guidance for MCRS
03/20/2020	Guidance	DBHDD Clubhouse Programs; CYF AD Prevention
03/21/2020	FAQs	Coronavirus: COVID-19 Provider FAQs
03/25/2020	Special Bulletin	Deaf Services
03/26/2020	Special Bulletin	Continuing Education for Professional Counselors, Social Workers, and Marriage and Family Therapists
03/26/2020	DBHDD Policy (in PolicyStat)	COVID-19 2020: DBHDD Community Behavioral Health Services Policy Modifications – 3/26/2020 (version 1)
03/27/2020	Guidance	For Regions: All Regions & GHVP Providers - Temporary Measures to Address Tenant Loss of Income during COVID-19
03/27/2020	Guidance	For Providers: All Regions & GHVP Providers - Temporary Measures to Address Tenant Loss of Income during COVID-19

03/30/2020	Memorandum	COVID-19 Guidance for Supported Employment Providers
03/30/2020	Special Bulletin/ Memo	COVID-19 Emergency - Staff Training Related to CPR and Crisis Intervention
03/31/2020	Special Bulletin	Billing for Medicaid Telehealth for BH Services, COVID-19 Emergency Staff Training Related to CPR and Crisis Intervention
04/01/2020	Guidance	DBHDD Take-Homes COVID-19
04/02/2020	Special Bulletin	Medication Assisted Treatment Guidance for Take-Home Medication and Telehealth, DBHDD Mental Health Wellness Resources, Telehealth Learning and Consultation (TLC) Tuesdays
04/02/2020	First release	Summary of COVID-19 Policy Modifications (Table of DBHDD policy revisions with dates)
04/02/2020	DBHDD Policy (in PolicyStat)	COVID-10: DBHDD Community Behavioral Health Services Policy Modifications – 4/2/2020 (policy version 2)
04/03/2020	Guidance	DBHDD Guidance for Housing Outreach Coordinators – COVID-19
04/03/2020	Guidance	Guidance for Residential Services – COVID-19
04/03/2020	FAQs	Coronavirus: COVID-19 Provider FAQs
04/06/2020	Special Bulletin	Background Check Variance, Georgia COVID-19 Emotional Support Line, 2x2 Series: Daily Self-Care Tips and Support for Health Care and Emergency Response Workers, Telehealth Training and Consultation (TLC) Tuesdays
04/07/2020	Guidance	Guidance PATH Providers – COVID-19
04/08/2020	DBHDD Policy (in PolicyStat)	COVID-10: DBHDD Community Behavioral Health Services Policy Modifications – 4/8/2020 (policy version 3)
04/09/2020	Guidance	DBHDD Guidance on GHVP Bridge Funding – COVID-19
04/23/2020	DBHDD Policy (in PolicyStat)	COVID-10: DBHDD Community Behavioral Health Services Policy Modifications – 4/23/2020 (policy version 4)
04/24/2020	Special Bulletin	Behavioral Health Telemedicine and Telephonic Guidance, IDD Connects Scheduled Downtime, APPENDIX K Webinar Presentations and Operational Guidance, Background Check Variance
04/24/2020	Guidance	DBHDD Medication Assisted Treatment Guidance for the COVID-19
05/11/2020	Special Bulletin	Emergency Response DBHDD Community Settings: Reopening Recommendations, Appendix K Operational Guidance (IDD providers), Appendix K Webinar Presentations (IDD providers)
05/20/2020	Special Bulletin	Behavioral Health Community Support Team & Community Support Individual Billing Guidance, Behavioral Health Group Services & Telehealth Allowances,

		I/DD Appendix K Webinar & Community Settings Reopening Guidance (I/DD Providers), 2x2 Series: Daily Self Care Tips & Support for Health Care and Emergency Response Workers
05/20/2020	Guidance	Behavioral Health Community Support Team & Community Support Individual Billing Guidance
06/02/2020	Special Bulletin	BH Provider Manual Revisions due to COVID-19, Change in Fingerprinting Process
07/24/2020	DBHDD Policy (in PolicyStat)	COVID-19 2020: DBHDD Community Behavioral Health Services Policy Modifications
08/18/2020	Special Bulletin	Important Announcement: Image Incident Reporting Changes
09/21/2020	DBHDD Policy (in PolicyStat)	COVID-19 2020: DBHDD Community Behavioral Health Services Policy Modifications
10/01/2020	Network News	Volume 32: DBHDD COVID-19 2020: DBHDD Community Behavioral Health Services Policy Modifications – 9/21/2020; The Georgia Collaborative ASO Quality Reviews Update
10/06/2020	Special Bulletin	National Public Health Emergency Extended effective 10/23/2020 for 90 days.

BE INFORMED

NETWORK BULLETIN

Filed 11/29/23



A message from **Commissioner Fitzgerald** related to Coronavirus

DBHDD and you, the provider network, play a vital role as Georgia's behavioral health and IDD Safety Net. Critical services must remain open. State officials are working to sustain services and protect the health and safety of individuals we serve, practitioners, and communities. We are closely following the evolving guidance from federal and state officials. In this update, we are providing additional guidance and flexibility to support you in the continuity of services.



As Governor Kemp has advised, all providers should use their best professional judgment when required to visit an individual's home. The most up to date information, including guidance for clinicians and those staffing individuals' homes can be found on the CDC and Georgia DPH websites.

DBHDD will continue to provide updates via the Provider Newsletter: Network News. Should you have questions, please submit them to our Provider Relations team via the **Provider** Issue Management System or submit an email to DBHDD.Provider@dbhdd.ga.gov.

IDD Services

Yesterday, DCH released a memo that is applicable to NOW and COMP providers, titled COVID-19 Response and HCBS Operations. In the memo, you will note that Case Managers (i.e. Support Coordination Agencies) may continue to use telephonic means to perform client contacts. Support Coordinators should continue to use the IQOMR and make a note when unable to assess a certain question due to the need for visual confirmation. The memo also addresses Adult Day Programs and recommends that this population avoid group settings and practice social distancing. Please review the memo linked below.

State Support Coordinators may use telephonic means to perform client contacts.

DCH MEMOCOVID-19 RESPONSE AND HCBS **OPERATIONS**

BH Services

Effective immediately, DBHDD has removed restrictions on telemedicine services that, until today, had restrictions noted within the service guidelines. In addition, we are waiving requirements for face to face contacts where the service guidelines note a minimum number or ratio of face to face contacts. Please review the linked memorandum for specific allowances. At this time, these allowances will be in place until April 30, 2020.

Many of you have asked questions about fiscal support during the pandemic. We do not have any specific information yet regarding the distribution of any emergency funds. Should this information become available, I assure you we will share it with you as quickly as possible.

Office of Provider Relations

Director

Lynn Copeland

Senior Provider Relations Manager

Carole Crowley

Provider Relations Managers

Sharon Pyles Tim Strickland Lisa Sweat



For Provider Relations inquiries, please contact us at DBHDD.Provider@dbhdd.ga.gov







Judy Fitzgerald, Commissioner

Office of the Commissioner

MEMORANDUM

TO: Judy Fitzgerald, Commissioner

FROM: Community Providers of Behavioral Health and Intellectual and

Developmental Disabilities Services

DATE: March 14, 2020

RE: Service Allowances due to COVID-19

DBHDD and you, the provider network, play a vital role as Georgia's behavioral health and IDD Safety Net. Critical services must remain open. State officials are working to sustain services and protect the health and safety of individuals we serve, practitioners, and communities. We are closely following the evolving guidance from federal and state officials. In this update, we are providing additional guidance and flexibility to support you in the continuity of services.

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Many of you have asked questions about fiscal support during the pandemic. We do not have any specific information yet regarding the distribution of any emergency funds. Should this information become available, I assure you we will share it with you as quickly as possible. Thank you for your continued commitment to Georgia's safety net.

Attachment: Behavioral Health Service Allowances, 3/14/2020

Judy Fitzgerald, Commissioner

Office of the Commissioner

D-B-H-D-D

Attachment 1: Behavioral Health Service Allowances, 3/14/2020

Effective March 14, 2020 and through April 30, 2020, the following allowances for DBHDD Behavioral Health Services are in effect.

Case 1:16-cv-03088-ELR

Telemedicine Allowances:

Currently, the DBHDD Behavioral Health Provider Manual has this clause associated with several services:

To promote access, providers may use Telemedicine as a tool to provide direct interventions to individuals Telemedicine may only be utilized when delivering this service to an individual for whom English is not for whom English is not their first language (one-to-one via Telemedicine versus use of interpreters) their first language. For the specific services which have this clause, through April 30, 2020, DBHDD will waive the Service Accessibility requirement to allow for individuals to access services via Telemedicine. All other service requirements must be met (practitioner requirements, documentation, consent, adherence to IRP content, etc.), especially content defined in Part II, Section I, 1.B.16.a-c.

DBHDD will also allow Part II, Section I, 1.B.16.d. to be expanded as a part of the waiver above, allowing i. and ii. below to apply to the Telemedicine allowances defined in this guidance through April 30, 2020. Providers can apply the language in green to clearly interpret the allowance as it will be defined during this waiver period:

individuals for whom English is not their first language (one-to-one versus through use of interpreters) or To promote access, providers who are using Telemedicine 1) as a tool to provide direct interventions to 2) for the waiver period associated with COVID-19 prevention measures are exempt from:

- The required percent of community-based services ratios defined in the Service Definitions herein; and
- The required minimum face-to-face expectations (allowing face-to-face to be via telemedicine).

Impacted Services:

Youth Peer Support - IND Addictive Disease Services and Support Addictive Diseases Peer Support - IND Behavioral Health Assessment Intensive Case Management Community Support Team Individual Counseling Crisis Intervention Family Counseling Case Management Family Training

Treatment Court Services - Adult Addictive Diseases Peer Whole Health and Wellness-IND Mental Health Peer Support - IND Nursing Assessment and Health Intensive Family Intervention Parent Peer Support - IND Service Plan Development Psychosocial Rehab - IND **Psychological Testing**

In addition to the telemedicine allowances noted above, effective now until April 30, 2020, the following service requirements will be adjusted as noted:

Service	Existing DBHDD Provider Manual Requirement	Waiver through Anril 30, 2020
ADSS	1. The agency providing this service must be a Tier 1 or Tier 2	1. The agency providing this service must be a
	provider, an Intensive Outpatient Program (IOP) specialty	Tier 1 or Tier 2 provider, an Intensive
	provider, or a WTRS provider. Contact must be made with the	Outpatient Program (IOP) specialty provider,
	individual receiving ADSS services a minimum of twice each	or a WTRS provider. Contact must be made
	month. At least one of these contacts must be face-to-face and	with the individual receiving ADSS services a
	the second may be either face-to-face or telephone contact	minimum of twice each month.
	depending on the individual's support needs and documented	
	preferences.	
	2. At least 50% of ADSS service units must be delivered face-to-	2. Waived completely
	face with the identified individual receiving the service. In the	
	absence of the required monthly face-to-face contact and if at	
	least two unsuccessful attempts to make face-to-face contact	

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	have been tried and documented, the provider may bill for a maximum of two telephone contacts in that specified month.	
Assertive	6. At least 80% of all service units must involve face-to-face contact with individuals Fighty percent (80%) or more of face-to-	6. Waived completely
Treatment	face service units must be provided outside of program offices in	
	locations that are comfortable and convenient for individuals (including the individual's home, based on individual need and	
	preference and clinical appropriateness).	
	7. During the course of ACT service delivery, the ACT Team will	7. During the course of ACT service delivery,
	provide the intensity and frequency of service needed for each	the ACT Team will provide the intensity and
	individual. ACT teams are expected to achieve fidelity with the	frequency of service needed for each
	DACTS Model. To achieve a score of ""4"" in the Frequency of	individual. ACT Teams must provide a
	Contact Measure within DACTS, ACT Teams must provide a	median of 3-3.99 contacts per week across a
	median of 3-3.99 face-to-face contacts per week across a sample	sample of agency's ACT individuals. This
	of agency's ACT individuals. This measure is calculated by	measure is calculated by determining the
	determining the median of the average weekly face-to-face	median of the average weekly contacts of
	contacts of each individual in the sample. At least one of these	each individual in the sample. At least one of
	monthly contacts must include symptom	these monthly contacts must include
	assessment/management and management of medications.	symptom assessment/management and
		management of medications.
	8. During discharge transition, the number of face-to-face visits	8. During discharge transition, the number of
	per week will be determined based on the person's mental health	contacts per week will be determined based
	acuity with the expectation that these individuals participating in	on the person's mental health acuity with the
	ACT transitioning must receive a minimum of 4 face-to-face	expectation that these individuals
	contacts per month during the documented active transition	participating in ACT transitioning must
	period.	receive a minimum of 4 contacts per month
		during the documented active transition
		period.
	14. It is expected that 90% or more of the individuals have face to	14. It is expected that 90% or more of the
	face contact with more than one staff member in a 2-week	individuals have contact with more than one
	period."	staff member in a 2-week period."

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Case Management	6. Contact must be made with the individual receiving CM a minimum of two (2) times a month. At least one of the monthly contacts must be face-to-face in non-clinic/community-based setting and the other may be either face-to-face or telephone contact (denoted by the UK modifier) depending on the individual's identified support needs. While the minimum number of contacts is stated above, individual clinical need is always to be met and may require a level of service higher than the established minimum criteria for contact.	6. Contact must be made with the individual receiving CM a minimum of two (2) times a month. When the telephone modality is used, it is denoted by the UK modifier. While the minimum number of contacts is stated above, individual clinical/support needs are always to be met and may require a level of service higher than the established minimum criteria for contact.
	7. At least 50% of CM service units must be delivered face-to-face with the identified individual receiving the service and the majority of all face-to-face service units must be delivered in nonclinic settings over the authorization period (these units are specific to single individual records and are not aggregate across an agency/program or multiple payers).	7. At least 50% of CM units must be provided directly to the individual (with the remaining contacts allowed for collateral contacts).
	8. The majority of all face-to-face service units must be delivered in non-clinic settings (i.e. any place that is convenient for the individual such as FQHC, place of employment, community space) over the course of the authorization period (these units are specific to single individual consume records and are not aggregate across an agency/program or multiple payers).	8. Waived completely.
	9. In the absence of meeting the minimum monthly face-to-face contact and if at least two (2) unsuccessful attempts to make face-to-face contact have been tried and documented, the provider may bill for a maximum of one (1) telephone contact in that specified month (denoted by the UK modifier). Billing for collateral contact only may not exceed 30 consecutive days.	9. Waived completely.

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	10. After four (4) unsuccessful attempts at making face to face contact with an individual, the CM and members of the treatment team will re-evaluate the IRP and utilization of services.	10. After four (4) unsuccessful attempts at making contact with an individual, the CM and members of the treatment team will reevaluate the IRP and utilization of services.
	13. When the primary focus of CM is on medication maintenance, the following allowances apply: a. These individuals are not counted in the off-site service requirement or the individual-to-staff ratio; and b. These individuals are not counted in the monthly face-to-face contact requirement; however, a minimum of one (1) face-to-face contact is required every three (3) months; and monthly calls are an allowed billable service."	13. Waived completely.
Community Support Individual	3. Contact must be made with youth receiving Community Support services a minimum of twice each month. At least one of these contacts must be face-to-face and the second may be either face-to-face or telephone contact (denoted by the UK modifier) depending on the youth's support needs and documented preferences of the family. 5. In the absence of the required monthly face-to-face contact and if at least two unsuccessful attempts to make face-to-face contact have been tried and documented, the provider may bill for a maximum of two telephone contacts in that specified month (denoted by the UK modifier).	3. Contact must be made with youth receiving Community Support services a minimum of twice each month. Contacts must be face-to-face or via telephone contact (denoted by the UK modifier) depending on the youth's support needs. 5. Waived completely
Community Support Team	3. At least 60% of all service units must involve face-to-face contact with individuals. The majority (51% or greater) of face-to-face service units must be provided outside of program offices in locations that are comfortable and convenient for individuals (including the individual's home, based on individual need and preference and clinical appropriateness).	3. Waived completely.

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	4. A minimum of four (4) face-to-face visits must be delivered	4. A minimum of four (4) contacts must be
	monthly by the CST. Additional contacts above the monthly	delivered monthly by the CST. Additional
	minimum may be either face-to-face or telephone collateral	contacts above the monthly minimum may
	contact depending on the individual's support needs and keeping	be either face-to-face or telephone collateral
	to the expected 60% of units being face-to-face.	contact depending on the individual's
		support needs.
	1. A CST shall have a minimum of 3.5 team members which must	1. A CST shall have a minimum of 3.5 team
	include:	members which must include:
	c. (.5 FTE) A half-time registered nurse (RN). This person will	c. (.5 FTE) A half-time registered nurse (RN).
	Nursing face-to-face time with each individual served by the team	This person will Nursing contacts with each
	is determined based on the IRP, physician assessment, and is	individual served by the team is determined
	delivered at a frequency that is clinically and/or medically	based on the IRP, physician assessment, and
	indicated."	is delivered at a frequency that is clinically
		and/or medically indicated."
Community	Community Transition Planning (CTP) is a service provided by Tier	Community Transition Planning (CTP) is a
Transition	1, Tier II and IFI providers to address the care, service, and	service provided by Tier 1, Tier II and IFI
Planning	support needs of youth to ensure a coordinated plan of transition	providers to address the care, service, and
	from a qualifying facility to the community. Each episode of CTP	support needs of youth to ensure a
	must include contact with the individual, family, or caregiver with	coordinated plan of transition from a
	a minimum of one (1) face-to-face contact with the individual	qualifying facility to the community. Each
	prior to release from a facility.	episode of CTP must include contact with the
		individual, family, or caregiver prior to
		release from a facility.
Community	3. Service may be provided by phone (although 50% must be	3. Service may be provided by phone
Transition Peer Support	provided face to face, telephonic contacts are limited to 50%).	
Psychological	Psychological testing consists of a face-to-face assessment of	Psychological testing consists of an
Testing	emotional functioning, personality, cognitive functioning (e.g.	assessment of emotional functioning,
	thinking, attention, memory) or intellectual abilities using an	personality, cognitive functioning (e.g.
	objective and standardized tool that has uniform procedures for	thinking, attention, memory) or intellectual
		abilities using an objective and standardized

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	administration and scoring and utilizes normative data upon	tool that has uniform procedures for
	which interpretation of results is based	administration and scoring and utilizes
	This continue contract the form to find a factor of the first of the f	normative data upon wnich interpretation of
	Inis service covers both the race-to-race administration of the test instrument(s) by a qualified examiner as well as the time	results is based
	spent by a psychologist or physician (with the proper education	This service covers both the direct
	and training) interpreting the test results and preparing a written	administration of the test instrument(s) by a
	report in accordance with CPT procedural guidance.	qualified examiner as well as the time spent
		by a psychologist or physician (with the
		proper education and training) interpreting
		the test results and preparing a written
		report in accordance with CPT procedural
		guidance.
High Utilizer	6. Using assertive engagement skills, the HUM Navigator will	6. Using assertive engagement skills, the
Management	function to perform and report on the following 30-60-90 Day	HUM Navigator will function to perform and
	Activities:	report on the following 30-60-90 Day
	Within 30 days (Rapid Intensive Engagement)	Activities:
	 have had face-to-face contact with individual 	Within 30 days (Rapid Intensive Engagement)
		 have had contact with individual
Intensive	Intensive Customized Care Coordination is differentiated from	Intensive Customized Care Coordination is
Customized	traditional case management by:	differentiated from traditional case
Care	 The frequency of the coordination: an average of one face-to- 	management by:
Coordination	face meeting weekly.	 The frequency of the coordination: an
		average of one meeting with the
		youth/family weekly.
	15. The Care Coordinator will average 1 face-to-face per week per	15. The Care Coordinator will average 1
	individual served.	contact per week per individual served.
Intensive	4. At least 60% of service units must be provided face-to-face with	4. Therapy intervention can be provided via
Family	youth and their families and 80% of all face-to-face service units	Telemedicine. Coordination and skills
Intervention	must be delivered in non-clinic settings over the authorization	enhancement service components may be
	period.	provided telephonically.

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	ii. Meet at least twice a month with families face-to-face or more	ii. Engage at least twice a month with the
	often as clinically indicated.	families or more often as clinically indicated.
Parent Peer	4. Contact must be made with the individual receiving PPS	4. Contact must be made with the individual
Support -	services a minimum of twice each month. At least one of these	receiving PPS services a minimum of twice
Individual	contacts must be face-to-face and the second may be either face-	each month.
	to-face or telephone contact depending on the individual's	
	support needs and documented preferences.	
	5. At least 50% of PPS service units must be delivered face-to-face	5. Waived completely
	with the family/youth receiving the service. In the absence of the	
	required monthly face-to-face contact and if at least two	
	unsuccessful attempts to make face-to-face contact have been	
	tried and documented, the provider may bill for a maximum of	
	two telephone contacts in that specified month.	
	Service Accessibility:	Service Accessibility:
	2. PPS may be provided at a service site, in the recipient's home,	2. PPS may be provided at a service site, in
	or in any community setting appropriate for providing the services	the recipient's home, or in any community
	as specified in the recipient's behavioral health recovery plan; via	setting appropriate for providing the services
	phone (although 50% must be provided face to face, telephonic	as specified in the recipient's behavioral
	contacts are limited to 50%).	health recovery plan; via phone
Youth Peer	2. YPS may be provided at a service site, in the recipient's home,	2. YPS may be provided at a service site, in
Support -	or in any community setting appropriate for providing the services	the recipient's home, or in any community
Individual	as specified in the recipient's behavioral health recovery plan; via	setting appropriate for providing the services
	phone (although 50% must be provided face to face, telephonic	as specified in the recipient's behavioral
	contacts are limited to 50%).	health recovery plan; via phone
Psychosocial	4. In the absence of the required monthly face-to-face contact	4. Waived completely.
Rehabilitation-	and if at least two unsuccessful attempts to make face-to-face	
Individual	contact have been tried and documented, the provider may bill	
	for a maximum of two telephone contacts in that specified	
	month.	

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	6. When the primary focus of PSR-I is for medication	6. When the primary focus of PSR-I is for
	maintenance, the following allowances apply:	medication maintenance, the following
	a. These individuals are not counted in the offsite service	allowances applies:
	requirement or the individual-to-staff ratio; and	a. These individuals are not counted in the
	b. These individuals are not counted in the monthly face-to-face	offsite service requirement or the individual-
	contact requirement; however, face-to-face contact is required	to-staff ratio;
	every 3 months and monthly calls are an allowed billable service.	
Peer Support	REQUIRED COMPONENTS: 3. At least 60% of all service units must 3. Waived completely.	3. Waived completely.
WHW -	involve face-to-face contact with individuals. The remainder of	
Individual	direct billable service includes telephonic intervention directly	
	with the person or is contact alongside the person to navigate and	
	engage in health and wellness systems/activities.	

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Behavioral Health Service Provision

Telemedicine and Telehealth

Facilitator:

Jennifer Hunt-Manchester

Presenters:

Melissa Sperbeck Monica Johnson Wendy Tiegreen Lynn Copeland March 20, 2020

Updated March 18, 2020

This document provides guidance related to service adjustments made during the COVID-19 crisis.

patient's health. Electronic communication means the use of interactive telecommunications equipment that includes, at a minimum, audio and phone, text, email, monitoring, and other modalities of interaction as being enabled. Very specifically, DBHDD and DCH are enabling telephonic video equipment permitting two-way, real time interactive communication between the patient and the practitioner at the distant site. In response to COVID-19, Federal and State authorities are referencing the term "telehealth" which is a broad definition which encompasses Telemedicine is the use of medical information exchanged from one secured site to another via electronic communications to improve a interventions for services and all references herein qualify that process.

Case 1:16-cv-03088-ELR

Telemedicine and Telephonic Allowances:

On March 14, 2020 the following allowance was provided to the field related to telemedicine:

Currently, the DBHDD Behavioral Health Provider Manual has this clause associated with several services:

To promote access, providers may use Telemedicine as a tool to provide direct interventions to individuals for whom English is not their first language (one-to-one via Telemedicine versus use of interpreters). Telemedicine may only be utilized when delivering this service to an individual for whom English is not their first language.

For the specific services which have this clause, through April 30, 2020, DBHDD will waive the Service Accessibility requirement to allow for individuals to access services via Telemedicine. All other service requirements must be met (practitioner requirements, documentation, consent, adherence to IRP content, etc.), especially content defined in Part II, Section I, 1.B.16.a-c.

Telemedicine allowances defined in this guidance through April 30, 2020. Providers can apply the language in green to clearly interpret DBHDD will also allow Part II, Section I, 1.B.16.d. to be expanded as a part of the waiver above, allowing i. and ii. below to apply to the the allowance as it will be defined during this waiver period:

To promote access, providers who are using Telemedicine 1) as a tool to provide direct interventions to individuals for whom English is not their first language (one-to-one versus through use of interpreters) or 2) for the waiver period associated with COVID-19 prevention measures are exempt from:

- The required percent of community-based services ratios defined in the Service Definitions herein; and
- The required minimum face-to-face expectations (allowing face-to-face to be via telemedicine)

Update as of March 19, 2020:

able to revise the notice provided to the field on March 14, 2020 and to provide an expansion in the use of the telephone as a tool for the direct With a series of guidance from our federal partners in the past two days and with the DCH Banner Message dated March 17, 2020, DBHDD is implemented and described herein: https://www.hhs.gov/hipaa/for-professionals/special-topics/emergency-preparedness/notificationprovision of service (including modes such as Apple FaceTime, Facebook Messenger video chat, Google Hangouts video, or Skype as enforcement-discretion-telehealth/index.html)

the allowance and impact on DBHDD behavioral health services. The following excerpt from the Banner message provides the rationale for the All Medicaid providers should review the DCH Banner Message posted on the MMIS website. DBHDD offers the below information related to allowances and requirements noted below.

The codes that will be billed must be identified as "telehealth services" by utilizing a telehealth Place of Service (POS) code or a **telehealth modifier (e.g., GT)**. Services listed in Table A have a "GT" modifier code available. Therefore, these services may be provided with via telemedicine and telephonic methods The GT modifier must be used to denote either service modality.

ABLE A

Addictive Diseases Services and SupportIntensive Case ManagementAddictive Diseases Peer Support - INDIntensive Family InterventionAssertive Community Treatment*Mental Health Peer Support - INDBehavioral Health AssessmentParent Peer Support - INDCase ManagementParent Peer Support - INDCommunity Support Team*Peer Whole Health and Wellness- INICommunity SupportPsychological TestingDiagnostic AssessmentPsychological Rehab - INDFamily CounselingService Plan DevelopmentFamily TrainingTreatment Court Services - Adult Ado		
Intensive Family Intervention Mental Health Peer Support - IN Nursing Assessment and Health* Parent Peer Support - IND Peer Whole Health and Wellness Psychiatric Treatment Psychological Testing Psychological Rehab - IND Service Plan Development Treatment Court Services - Adult	Addictive Disease Services and Support	Intensive Case Management
Mental Health Peer Support - IN Nursing Assessment and Health* Parent Peer Support - IND Peer Whole Health and Wellness Psychiatric Treatment Psychological Testing Psychosocial Rehab - IND Service Plan Development Treatment Court Services - Adult		Intensive Family Intervention
Nursing Assessment and Health* Parent Peer Support - IND Peer Whole Health and Wellness Psychiatric Treatment Psychological Testing Psychological Rehab - IND Service Plan Development Treatment Court Services - Adult	Assertive Community Treatment*	
Parent Peer Support - IND Peer Whole Health and Wellness Psychiatric Treatment Psychological Testing Psychosocial Rehab - IND Service Plan Development Treatment Court Services - Adult	Behavioral Health Assessment	
Peer Whole Health and Wellness Psychiatric Treatment Psychological Testing Psychosocial Rehab - IND Service Plan Development Treatment Court Services - Adult		Parent Peer Support - IND
Psychiatric Treatment Psychological Testing Int Psychosocial Rehab - IND Service Plan Development Treatment Court Services - Adu		Peer Whole Health and Wellness- IND
Psychological Testing Psychosocial Rehab - IND Service Plan Development Treatment Court Services - Adu		
Int Psychosocial Rehab - IND Service Plan Development Treatment Court Services - Adu		
Service Plan Development Treatment Court Services - Adu	int	
		Treatment Court Services - Adult Addictive Diseases
Individual Counseling Youth Peer Support - IND	Individual Counseling	Youth Peer Support - IND

*indicates a service-specific requirement related to telemedicine and telehealth, noted in Table C

modifier (in the Provider Manual or IT system). In order to be in compliance with Medicaid requirement noted above, providers must submit the There are other services that are allowable via telemedicine or telephonic methods noted in Table B. However, these services do not have a GT Place of Service (POS) code "02" on Medicaid claims to denote the methodology.

At this time, 02 Place of Service code 02 is not activated for DBHDD state-funded claims. Therefore, state-funded service claims may be submitted without the Place of Service (POS) code "02"

Table B

Assertive Community Treatment*	Psychosocial Rehabilitation – Group (no more than 6 participants)
High Utilizer Management	Peer Support Whole Health & Wellness -Group (no more than 6 participants)
Intensive Customized Care Coordination	Group Training (no more than 6 participants)
Supported Employment	Group Counseling (no more than 6 participants)
Task-Oriented Rehabilitation Services	SA Intensive Outpatient Program (no more than 6 participants)
Treatment Court Services - Adult AD	Mental Health Peer Support (no more than 6 participants)
WTRS Outpatient Services	
(in accordance with unbundled services named)	Parent Peer Support - Group (no more than 6 participants)
	Youth Peer Support – Group (no more than 6 participants)
	AD Peer Support Program (no more than 6 participants)
*indicates a service-specific requirement related to telemedicine and telehealth, noted in Table C	

When the telephone or telemedicine is used for the provision of one of these services, the note shall document the use of that modality.

Telemedicine and services provided via telephone must meet requirements noted in the Provider Manual. However, for this time period, DBHDD will allow documentation of verbal consent for telemedicine and telephonic services.

Please note that, for DBHDD services, originating sites may include traditional locations as well as homes, schools, and other communitybased settings (see DCH Telehealth Guidance, page 19. This guidance is located on the GAMMIS website. Providers may locate the Telehealth Guidance manual by accessing the following link: www.mmis.georgia.gov. Select the "Provider Information" tab, then select "Provider Manuals." Scroll down to the locate the Telehealth/Telemedicine manual). For consistency, the provisions below applicable to state funded services mirror DCH requirements noted in their bulletin:

Expansion of the use of telehealth will be supported in the following manner:

- Allowing telehealth services to be provided during the period of COVID-19 emergency response by the following modalities:
- Telephone communication
- Use of webcam or other audio and video technology
 - Video cell phone communication
- All services must be deemed medically necessary 3. %
- Qualified healthcare providers must continue to comply with state telehealth laws and regulations, including professional licensure, scope of practice, standards of care, patient consent and other payment requirements for Medicaid members.

In addition to the telemedicine allowances noted above, for effective now until April 30, 2020, the following service requirements will be adjusted as noted in Table 3

March 19 updates are in red font. TABLE C

	_	
Service	Existing DBHDD Provider Manual Requirement	Waiver through April 30, 2020
ADSS	1. The agency providing this service must be a Tier 1 or Tier 2	1. The agency providing this service must be a Tier 1 or
	provider, an Intensive Outpatient Program (IOP) specialty	Tier 2 provider, an Intensive Outpatient Program (IOP)
	provider, or a WTRS provider. Contact must be made with	specialty provider, or a WTRS provider. Contact must be
	the individual receiving ADSS services a minimum of twice	made with the individual receiving ADSS services a
	each month. At least one of these contacts must be face-to-	minimum of twice each month.
	face and the second may be either face-to-face or telephone	
	contact depending on the individual's support needs and	
	documented preferences.	
	2. At least 50% of ADSS service units must be delivered face-	2. Waived completely
	to-face with the identified individual receiving the service. In	
	the absence of the required monthly face-to-face contact and	
	if at least two unsuccessful attempts to make face-to-face	
	contact have been tried and documented, the provider may	
	bill for a maximum of two telephone contacts in that	
	specified month.	
Assertive	6. At least 80% of all service units must involve face-to-face	6. Waived completely
Community	contact with individuals. Eighty percent (80%) or more of	
Treatment	face-to-face service units must be provided outside of	
	program offices in locations that are comfortable and	
	convenient for individuals (including the individual's home,	

based on individual need and preference and clinical	
 appropriateness).	
7. During the course of ACT service delivery, the ACT Team	7. During the course of ACT service delivery, the ACT
will provide the intensity and frequency of service needed for	Team will provide the intensity and frequency of service
each individual. ACT teams are expected to achieve fidelity	needed for each individual. ACT Teams must provide a
with the DACTS Model. To achieve a score of ""4"" in the	median of 3-3.99 contacts per week across a sample of
Frequency of Contact Measure within DACTS, ACT Teams	agency's ACT individuals. This measure is calculated by
must provide a median of 3-3.99 face-to-face contacts per	determining the median of the average weekly contacts
week across a sample of agency's ACT individuals. This	of each individual in the sample. At least one of these
measure is calculated by determining the median of the	monthly contacts must include symptom
average weekly face-to-face contacts of each individual in the	assessment/management and management of
sample. At least one of these monthly contacts must include	medications.
symptom assessment/management and management of	
medications.	
8. During discharge transition, the number of face-to-face	8. During discharge transition, the number of contacts
visits per week will be determined based on the person's	per week will be determined based on the person's
mental health acuity with the expectation that these	mental health acuity with the expectation that these
individuals participating in ACT transitioning must receive a	individuals participating in ACT transitioning must receive
minimum of 4 face-to-face contacts per month during the	a minimum of 4 contacts per month during the
documented active transition period.	documented active transition period.
14. It is expected that 90% or more of the individuals have	14. It is expected that 90% or more of the individuals
face to face contact with more than one staff member in a 2-	have contact with more than one staff member in a 2-
week period."	week period."
Special Conditions:	
1) In order to utilize any telephonic direct intervention, at	any telephonic direct intervention, at least to one face-to-face intervention between the ACT
team and the individual must occur per week.	
2) If there is any observation of decline in a person's state of wellness/recovery, the ACT team shall deploy to	of wellness/recovery, the ACT team shall deploy to
prevent the potential destabilization of that individual.	
3) The GT Modifier is only available for U1 and U2 Practitioners; providers should bill using this modifier for these	ners; providers should bill using this modifier for these
practitioner types. For other practitioner levels, POS 02 must be used for Medicaid claims.	must be used for Medicaid claims.
4) The multi-disciplinary team may be held through telemedicine or telephonic technology.	dicine or telephonic technology.

Case Management	6. Contact must be made with the individual receiving CM a minimum of two (2) times a month. At least one of the	6. Contact must be made with the individual receiving CM a minimum of two (2) times a month. When the
0		telephone modality is used, it is denoted by the UK
	clinic/community-based setting and the other may be either	modifier. While the minimum number of contacts is
	face-to-face or telephone contact (denoted by the UK	stated above, individual clinical/support needs are always
	modifier) depending on the individual's identified support	to be met and may require a level of service higher than
	needs. While the minimum number of contacts is stated	the established minimum criteria for contact.
	above, Individual clinical need is always to be met and may	
	minimum criteria for contact.	
	7. At least 50% of CM service units must be delivered face-to-	7. At least 50% of CM units must be provided directly to
	face with the identified individual receiving the service and	the individual (with the remaining contacts allowed for
	the majority of all face-to-face service units must be delivered	collateral contacts).
	in non-clinic settings over the authorization period (these	
	units are specific to single individual records and are not	
	aggregate across an agency/program or multiple payers).	
	8. The majority of all face-to-face service units must be	8. Waived completely.
	delivered in non-clinic settings (i.e. any place that is	
	convenient for the individual such as FQHC, place of	
	employment, community space) over the course of the	
	authorization period (these units are specific to single	
	individual consume records and are not aggregate across an	
	agency/program or multiple payers).	
	9. In the absence of meeting the minimum monthly face-to-	9. Waived completely.
	face contact and if at least two (2) unsuccessful attempts to	
	make face-to-face contact have been tried and documented,	
	the provider may bill for a maximum of one (1) telephone	
	contact in that specified month (denoted by the UK modifier).	
	Billing for collateral contact only may not exceed 30	
	consecutive days.	
	10. After four (4) unsuccessful attempts at making face to	10. After four (4) unsuccessful attempts at making
	face contact with an individual, the CM and members of the	contact with an individual, the CM and members of the
	treatment team will re-evaluate the IRP and utilization of	treatment team will re-evaluate the IRP and utilization of
	services.	services.
	13. When the primary focus of CM is on medication	13. Waived completely.
	maintenance, the following allowances apply:	
	a. These individuals are not counted in the off-site service	
	requirement or the individual-to-staff ratio; and	

	b. These individuals are not counted in the monthly face-to-face contact requirement; however, a minimum of one (1) face-to-face contact is required every three (3) months; and monthly calls are an allowed billable service."	
Community Support Individual	3. Contact must be made with youth receiving Community Support services a minimum of twice each month. At least one of these contacts must be face-to-face and the second may be either face-to-face or telephone contact (denoted by the UK modifier) depending on the youth's support needs and documented preferences of the family.	3. Contact must be made with youth receiving Community Support services a minimum of twice each month. Contacts must be face-to-face or via telephone contact (denoted by the UK modifier) depending on the youth's support needs.
	5. In the absence of the required monthly face-to-face contact and if at least two unsuccessful attempts to make face-to-face contact have been tried and documented, the provider may bill for a maximum of two telephone contacts in that specified month (denoted by the UK modifier).	5. Waived completely
Community Support Team	3. At least 60% of all service units must involve face-to-face contact with individuals. The majority (51% or greater) of face-to-face service units must be provided outside of program offices in locations that are comfortable and convenient for individuals (including the individual's home, based on individual need and preference and clinical appropriateness).	3. Waived completely.
	4. A minimum of four (4) face-to-face visits must be delivered monthly by the CST. Additional contacts above the monthly minimum may be either face-to-face or telephone collateral contact depending on the individual's support needs and keeping to the expected 60% of units being face-to-face.	4. A minimum of four (4) contacts must be delivered monthly by the CST. Additional contacts above the monthly minimum may be either face-to-face or telephone collateral contact depending on the individual's support needs.
	1. A CST shall have a minimum of 3.5 team members must include: c. (.5 FTE) A half-time registered nurse (RN). This person will Nursing face-to-face time with each individual served by the team is determined based on the IRP, physician assessment, and is delivered at a frequency that is clinically and/or medically indicated 1. A CST shall have a minimum of 3.5 team members which must include: 2. (.5 FTE) A half-time registered nurse (RN). This person will Nursing contacts with each individual served by team is determined based on the IRP, physician assessment, and is delivered at a frequency that is clinically and/or medically indicated 2. (.5 FTE) A half-time registered nurse (RN). This person will Nursing contacts with each individual served by team is determined based on the IRP, physician assessment, and is delivered at a frequency that is clinically and/or medically indicated 3. PECIAL CONDITIONS: If there is any observation of decline in a person's state of wellness/recovery.	1. A CST shall have a minimum of 3.5 team members which must include: c. (.5 FTE) A half-time registered nurse (RN). This person will Nursing contacts with each individual served by the team is determined based on the IRP, physician assessment, and is delivered at a frequency that is clinically and/or medically indicated."
	deploy to prevent the potential destabilization of that individual.	סנו סנו מי מימיני כי מיליווי ביטילי

Community Transition Planning	Community Transition Planning (CTP) is a service provided by Tier 1, Tier II and IFI providers to address the care, service, and support needs of youth to ensure a coordinated plan of transition from a qualifying facility to the community. Each episode of CTP must include contact with the individual, family, or caregiver with a minimum of one (1) face-to-face contact with the individual prior to release from a facility.	Community Transition Planning (CTP) is a service provided by Tier 1, Tier II and IFI providers to address the care, service, and support needs of youth to ensure a coordinated plan of transition from a qualifying facility to the community. Each episode of CTP must include contact with the individual, family, or caregiver prior to release from a facility.
Community Transition Peer Support	 Service may be provided by phone (although 50% must be provided face to face, telephonic contacts are limited to 50%). 	3. Service may be provided by phone
Psychological Testing	Psychological testing consists of a face-to-face assessment of emotional functioning, personality, cognitive functioning (e.g. thinking, attention, memory) or intellectual abilities using an objective and standardized tool that has uniform procedures for administration and scoring and utilizes normative data upon which interpretation of results is based This service covers both the face-to-face administration of the test instrument(s) by a qualified examiner as well as the time spent by a psychologist or physician (with the proper education and training) interpreting the test results and preparing a written report in accordance with CPT procedural guidance.	Psychological testing consists of an assessment of emotional functioning, personality, cognitive functioning (e.g. thinking, attention, memory) or intellectual abilities using an objective and standardized tool that has uniform procedures for administration and scoring and utilizes normative data upon which interpretation of results is based This service covers both the direct administration of the test instrument(s) by a qualified examiner as well as the time spent by a psychologist or physician (with the proper education and training) interpreting the test results and preparing a written report in accordance with CPT procedural guidance.
High Utilizer Management	 6. Using assertive engagement skills, the HUM Navigator will function to perform and report on the following 30-60-90 Day Activities: Within 30 days (Rapid Intensive Engagement) have had face-to-face contact with individual 	 6. Using assertive engagement skills, the HUM Navigator will function to perform and report on the following 30-60-90 Day Activities: Within 30 days (Rapid Intensive Engagement) have had contact with individual
Intensive Customized Care Coordination	Intensive Customized Care Coordination is differentiated from traditional case management by: • The frequency of the coordination: an average of one faceto-face meeting weekly. 15. The Care Coordinator will average 1 face-to-face per week per individual served.	Intensive Customized Care Coordination is differentiated from traditional case management by: • The frequency of the coordination: an average of one meeting with the youth/family weekly. 15. The Care Coordinator will average 1 contact per week per individual served.
Intensive Family Intervention	4. At least 60% of service units must be provided face-to-face with youth and their families and 80% of all face-to-face	4. Therapy intervention can be provided via Telemedicine. Coordination and skills enhancement service components may be provided telephonically.

	service units must be delivered in non-clinic settings over the authorization period.	
	ii. Meet at least twice a month with families face-to-face or	ii. Engage at least twice a month with the families or
-	A Court as cullifically illulcated.	A Court of court he most on the the individual contribution
Parent Peer Support -	 Contact must be made with the Individual receiving PPS services a minimum of twice each month. At least one of 	4. Contact must be made with the individual receiving PPS services a minimum of twice each month
Individual	these contacts must be face-to-face and the second may be	
	either face-to-face or telephone contact depending on the	
	individual's support needs and documented preferences.	
	5. At least 50% of PPS service units must be delivered face-to-	5. Waived completely
	face with the family/youth receiving the service. In the	
	absence of the required monthly face-to-face contact and if	
	at least two unsuccessful attempts to make face-to-face	
	contact have been tried and documented, the provider may	
	bill for a maximum of two telephone contacts in that	
	specified month.	
	Service Accessibility:	Service Accessibility:
	2. PPS may be provided at a service site, in the recipient's	2. PPS may be provided at a service site, in the recipient's
	home, or in any community setting appropriate for providing	home, or in any community setting appropriate for
	the services as specified in the recipient's behavioral health	providing the services as specified in the recipient's
	recovery plan; via phone (although 50% must be provided	behavioral health recovery plan; via phone
	face to face, telephonic contacts are limited to 50%).	
Youth Peer	2. YPS may be provided at a service site, in the recipient's	2. YPS may be provided at a service site, in the recipient's
Support -	home, or in any community setting appropriate for providing	home, or in any community setting appropriate for
Individual	the services as specified in the recipient's behavioral health	providing the services as specified in the recipient's
	recovery plan; via phone (although 50% must be provided	behavioral health recovery plan; via phone
	face to face, telephonic contacts are limited to 50%).	
Psychosocial	4. In the absence of the required monthly face-to-face	4. Waived completely.
Rehabilitation-	contact and if at least two unsuccessful attempts to make	
Individual	face-to-face contact have been tried and documented, the	
	provider may bill for a maximum of two telephone contacts in	
	that specified month.	
	6. When the primary focus of PSR-I is for medication	6. When the primary focus of PSR-I is for medication
	maintenance, the following allowances apply:	maintenance, the following allowances applies:
	a. These individuals are not counted in the offsite service	a. These individuals are not counted in the offsite service
	requirement or the individual-to-staff ratio; and	requirement or the individual-to-staff ratio;
	b. These individuals are not counted in the monthly face-to-	
	face contact requirement; however, face-to-face contact is	

	required every 3 months and monthly calls are an allowed billable service.	
Peer Support WHW - Individual	REQUIRED COMPONENTS: 3. At least 60% of all service units must involve face-to-face contact with individuals. The	3. Waived completely.
	remainder of direct biliable service includes telephonic intervention directly with the person or is contact alongside the person to navigate and engage in health and wellness systems/activities.	
Intensive Case	6. REQUIRED COMPONENTS: Maintain face-to-face contact	6. REQUIRED COMPONENTS: Maintain engagement with
Management	with individuals receiving Intensive Case Management	individuals receiving Intensive Case Management
	services, providing a supportive and practical environment that promotes recovery and maintain adherence to the	services, providing a supportive and practical environment that promotes recovery and maintain
	desired performance outcomes that have been established	adherence to the desired performance outcomes that
	ror individuals receiving ICM services. It is expected that frequency of face-to-face contact is increased when clinically	nave been established for individuals receiving ICM services. It is expected that frequency of face-to-face
	indicated in order to achieve the performance outcomes, and	contact is increased when clinically indicated in order to
	the intensity of service is reflected in the individual's IRP.	achieve the performance outcomes/mitigate escalating crisis, and the intensity of service is reflected in the individual's lips but this must at lost eccurate month
	7. REQUIRED COMPONENTS: A minimum of 4 face-to-face	
	visits must be delivered on a monthly basis to each consumer.	7. REQUIRED COMPONENTS: A minimum of 4 contacts
	Additional contacts may be either face-to-face or telephone collateral contact depending on the individual's support	must be delivered on a monthly basis to each consumer. At least one must be face-to-face (or more depending on
	needs, 60% of total units must be face-to-face contacts with	the individual's support needs).
	the individual.	
	8. REQUIRED COMPONENTS: At least 50% of all face-to-face	8-10. Waived Completely.
	service units must be delivered in non-clinic/community- based settings (i.e., any place that is convenient for the	
	individual such as a FQHC, place of employment, community	
	space) over the authorization period (these units are specific	
	to single individual records and are not aggregate across an	
	9. In the absence of monthly face-to-face contacts and if at	
	least two unsuccessful attempts to make face-to-face contact	
	have been tried and documented, the provider may bill for a	
	maximum of 2 telephone contacts in that specified month	
	(denoted by the UK modifier). This may occur for no more	
	than 60 consecutive days.	

	10. After 8 unsuccessful attempts at making face to face	
	collect with an individual, the icivi and members of the	
	treatment/support team will re-evaluate the standing	
	IRP and utilization of services.	
Nursing	REQUIRED COMPONENTS 3: Each nursing contact should	SPECIAL CONDITION: The review of vital signs is a crucial
Assessment and	document the checking of vital signs (Temperature, Pulse,	aspect of a health delivery plan for the individuals we
Health Services	Blood Pressure, Respiratory Rate, and weight, if medically	support (especially those with significant comorbidities)
	indicated or if	and, at the same time, DBHDD is open to flexibility. We
	related to behavioral health symptom or behavioral health	see our nursing services as key to that whole health
	medication side effect) in accordance with general psychiatric	delivery so the expectation will be that every other
	nursing practice.	Nursing Assessment service can waive vitals (i.e. 50% of
		contact would be via telemedicine or telephonic in which
		a good inquiry related to health status would be
		expected). If there is a Medication Administration
		intervention provided by a nurse within your agency, this
		can also qualify as a documented opportunity to check
		with the individual on all symptoms, health indicators and
		vitals, counting as 50% of the Nursing face-to-face
		contact (which can be noted in that Progress Note).



Judy Fitzgerald, Commissioner

Division of Behavioral Health Office of Adult Mental Health

To: DBHDD-contracted providers of Assertive Community Treatment (ACT)

and Community Support Team (CST)

From: Terri Timberlake, Ph.D., Director

Office of Adult Mental Health

Date: March 17, 2020

Re: COVID 19 guidance for ACT and CST

The current Coronavirus pandemic has sparked heightened health and safety concerns across our state. Our Department is hopeful that each provider is taking the recommended precautions to reasonably support your own wellbeing and that of your staff. Similarly, we expect health and safety measures to be taken to support the needs of individuals enrolled in ACT and CST. This population represents the most vulnerable, high need individuals served by our public behavioral health system. Without necessary support, these individuals face increased risk for crisis. As you are aware, this past weekend Commissioner Fitzgerald released communication addressing use of telemedicine and waiving requirements for face-to-face service delivery contacts where the service guidelines note a minimum number or ratio of face to face contacts through April 30, 2020. In addition to that allowance, below is guidance specific to ACT and CST service delivery.

- 1. If an ACT or CST enrolled individual is unreachable or refuses telemedicine for a period of 4 consecutive days, an in person, face-to- face therapeutic contact is expected to be attempted. ACT and CST team members making in person contacts should use Centers for Disease Control (CDC) recommended contact precautions for infectious diseases. (Telemedicine is defined as interactive, secure and confidential audio-visual communication between practitioner and client, provided by MDs/NPs/ physician extenders).
- 2. Telemedicine contact with ACT or CST enrolled individuals must remain consistent with the service definition, and include documented addressing of individual's needs, and IRP goals.
- 3. If there is indication of behavioral health decline/decompensation, including but not limited to behavioral health symptom escalation, behavioral health crisis, or new behavioral health symptoms, there must be a face to face intervention within 24 hours for ACT or CST enrolled individuals.
- 4. Interactions with enrolled individuals should include provision of education to clients about COVID19 symptoms and precautions, along with increased support related to virus fear and anxiety.

- ACT and CST team meetings must continue be held with all available team 5. members. This may be via a secure virtual portal (i.e., go-to-meeting, zoom or webex).
- In advance of any decrease in face-face visits, ACT and CST must work diligently to assist enrolled clients with obtaining sufficient supplies and necessities (i.e., food, medical supplies).

Please be aware that my office will facilitate scheduled annual DACTS fidelity reviews remotely via webex with audio-visual enablement. We are all in this together, we can choose to be proactive about the precautions that each of us can take and hopeful that the impact of the virus will decline. The CDC and World Health Organization websites contain information from experts that will help us take sensible steps and support our ability to make health promoting choices. The most up to date information, including guidance for clinicians and those staffing individuals' homes can be found on the Georgia DPH website. DBHDD will continue to provide updates via the Provider Newsletter: Network News. Should you have questions, please submit them to our Provider Relations team via the Provider Issue Management System or submit an email to DBHDD.Provider@dbhdd.ga.gov

We appreciate your continued commitment to the population whom we collectively serve.

Monica Johnson, Director, Division of Behavioral Health cc: Adrian Johnson, Assistant Director, Division of Behavioral Health Kimberly Briggs, Assistant Director, Office of Adult Mental Health Sarepta Archila, ACT and CST Unit Coordinator



Judy Fitzgerald, Commissioner

Division of Behavioral Health

TO: Opioid Treatment Programs of Georgia

FROM: State Opioid Treatment Authority

March 17, 2020

RE: Guidance for Infection Control and Prevention of COVID-19

Background: The Department of Behavioral Health and Developmental Disabilities (DBHDD) Office of Addictive Diseases (OAD) is Georgia's State Opioid Treatment Authority (SOTA). As such, DBHDD's OAD collaborates with other agencies in developing guidelines for establishing and/or closing Medication Assisted Treatment (MAT) Programs operating in Georgia. As the SOTA, DBHDD is also responsible for establishing guidelines for the administration of MAT programs. In this capacity we are concerned with the continuity of care for all individuals currently enrolled in Opioid Treatment Programs in Georgia. Due to the current challenge of addressing COVID-19 in our state, we are providing additional guidance.

Guidance: All Opioid Treatment Programs in Georgia should read and follow the attached DBHDD SOTA Policy Disaster Emergency Closure Procedure 01-284 State Opioid Treatment Authority Disaster Emergency Closure, 01-284. In addition, OTP's should follow the suggested guidelines of The Substance Abuse Mental Health Services Administration (SAMHSA) for COVID-19. https://www.samhsa.gov/medication-assisted-treatment/statutes-regulations-guidelines/covid-19-guidance-

 $\underline{otp?fbclid=IwAR1yqGWHEnjaQ0XgCkhmkZlFdElLtN4aAJ9vdjciYH6EmssKb6nzRZE1leI}$

CLINIC AND PATIENT SAFETY

Opioid Treatment Programs should implement procedures to monitor, recognize and manage patients, staff and visitors to their facility for the prevention of COVID-19.

OTPs should identify patients with signs and symptoms of respiratory infections before they enter the treatment area when possible. Patients with symptoms of a respiratory infection should put on a facemask (i.e., surgical mask) at check-in and keep it on until they leave the facility.

OTPs should encourage patients to inform staff of fever or respiratory symptoms immediately upon arrival at the facility.

OTPs should have patients call ahead to report fever or respiratory symptoms so the staff can be prepared for their arrival or make arrangements for them to appear after dosing hours to mitigate the risk of infecting others.

OTPs should post signs at entrances with instructions to patients with fever or symptoms of respiratory infection to alert staff so that the appropriate precautions can be implemented.

TAKE-HOME EXCEPTIONS

OTPs may request blanket exceptions for all stable patients to receive 28 days of take-home medication and up to 14 days of take-home medication for those patients who are less stable but who the OTP believes can safely handle this level of take-home medication. While this is the approved guidance of SAMHSA, they are leaning to the State SOTA to decide with each OTP, the appropriate clinical course of action for take-home medication. Georgia OTPs may submit a request for take-home medication for stable patients to attend OTPs three times per week. This will minimize to potential exposure to COVID-19.

For less stable patients as determined by the OTP, a staggered take-home schedule whereby half the OTP patients will present on Mondays, Wednesdays and Fridays, and the other half of OTP patients present on Tuesdays, Thursdays, and Saturdays, with the remaining days of the week allotted for take-homes is appropriate. These patients should receive no more than two consecutive take-homes at a time. This reduces the clinic's daily census in half and minimizes the potential exposure to COVID-19.

Blanket take-home medication exceptions will be approved for up to two weeks for patients with lab confirmed COVID-19 virus and patients with symptoms of a respiratory viral illness, with or without confirmation via COVID-19 viral testing. At the prescriber's discretion the request may be extended when clinically necessary.

MEDICATION SUPPLY

The US Drug Enforcement Agency (DEA) and the SOTA have agreed to collaborate on a case by case basis to ensure that impacted OTPs are not penalized/flagged for ordering more than what seems to be a normal amount of medication to address specific guest dosing needs for patients whose clinic has been impacted by COVID-19. OTPs should contact the SOTA as soon as possible to make the emergency request.

DBHDD CENTRAL REGISTRY DOSING INFORMATION

OTPs should, in accordance with the DBHDD SOTA Central Registry Policy, be sure that all patient dosing information is kept updated to facilitate the need for continuation of care. https://gadbhdd.policystat.com/policy/4647463/latest/

TELEHEALTH SERVICES

Effective immediately, DBHDD has removed restrictions on telemedicine services that, until today, had restrictions noted within the service guidelines. In addition, we are waiving requirements for face to face contacts where the service guidelines note a minimum number or ratio of face to face contacts. Please review the <u>linked memorandum</u> for specific allowances. At this time, these allowances will be in place until April 30, 2020.

Our response to COVID-19 is an ever-changing situation. Please know that as DBHDD receives more information about the needs of our state we will respond accordingly and keep you, our partners, well informed. For questions and further discussion please call 404-416-5225 or email Vonshurii.wrighten@dbhdd.ga.gov



Judy Fitzgerald, Commissioner

D·B·H·D·D

Office of Children, Young Adults & Families

TO: Georgia Apex Providers

Danté McKay, director, Office of Children, Young Adults, and Families FROM:

DATE: March 18, 2020

RE: Apex service provision during COVID-19 school closures

In response to the coronavirus (COVID-19) in Georgia, and Governor Kemp's Public Health State of Emergency guidance to increase efforts related to social distancing, DBHDD is supporting techniques that allow the continuation of services virtually. The health, safety, and well-being of the individuals we serve, practitioners, and staff, are DBHDD's top priority, and this decision has been made with those in mind. DBHDD is closely monitoring related developments and will provide additional information and updates in the coming weeks.

With schools closed in response to COVID-19, DBHDD would like to avoid disrupting services for students enrolled in the Georgia Apex Program. DBHDD will allow the school setting to be waived and expect that youth who have already been identified as Apex program recipients, or those identified as at-risk by that program's teachers, counselors, and/or administrative staff now that they are schooling from home, will be served/engaged. Any service which would have been provided prior to the COVID-19 response can and should continue to be provided via the DBHDD Services Allowances for COVID-19 memoranda and related FAQs released through the DBHDD.

Please be sure to regularly check the **CDC** and **Georgia DPH** websites for the most upto-date information about COVID-19, and remember to be vigilant about personal hygiene.

If you have additional questions that relate to COVID-19, please submit them to the provider relations email, DBHDD.Provider@dbhdd.ga.gov, so that they are properly tracked.

Thank you for your dedication and commitment to the people we serve.

Cc: Monica Johnson, Director, Division of Behavioral Health Wendy Tiegreen, Director, Office of Medicaid Coordination David Sofferin, Director, Public Affairs Lynn Copeland, Director, Provider Relations Lavla Fitzgerald, Program Manager, OCYF Danielle Jones, Program Coordinator, OCYF

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Georgia Department of Behavioral Health & Developmental Disabilities

Judy Fitzgerald, Commissioner

Office of Crisis Coordination

Guidance for DBHDD BHCC and CSU units regarding COVID-19

To: Crisis Unit Directors, Agency CEO

From: Debbie Atkins, LPC

Director of the Office of Crisis Coordination

As the safety net providers for crisis services in Georgia, you play a critical role in serving individuals who have very limited options for treatment. We at DBHDD continue to closely monitor and follow the evolving guidance from both federal and state officials. As we all embark on new territory of a Public Health Crisis, DBHDD would like to offer the following guidance for our crisis services.

- 1. Please follow the guidance provided by Georgia DPH and the CDC as it relates to screening individuals. Ask the appropriate questions and take vitals as a routine first step. If a person is considered as high risk or has developed symptoms, have them tested prior to admission on the unit. Keeping units available to our constituents is very important.
- 2. If a person is being referred to our system from a hospital via the electronic board, please know that all hospitals have a screening in place. Our medical clearance guidelines continue to be in place. If a person has a slightly elevated temperature and is still within our guidelines, please do not alter them for your unit. The hospital is providing the screens and will not transfer anyone who is at risk.
- 3. Please remember that our Emergency Departments are filling up quickly with potential cases and with individuals who are fearful they have been exposed. Being diligent in responding quickly and moving individuals from the emergency department will be a great help to our partners.
- 4. If a person develops symptoms while on the unit, we realize it will mean a stoppage of referrals until testing and stabilization occurs. Please

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consider that once the unit is exposed, stabilization of the individuals will still need to occur. As with other infectious diseases like the flu, stabilize, notify the appropriate authorities to request testing. If it is positive stoppage of admissions will need to happen until proper quarantine and cleaning occurs. If a person is stable enough to quarantine at home, follow proper discharge planning and ensure medication access while they are at home.

5. Lastly, please make sure you communicate any and all issues that will result in limiting your capacity as you are currently contracted. Communicate with your RSA and please copy both Adrian Johnson and Debbie Atkins. As we are monitoring the totality of the crisis system, we will need real time information as to issues that arise.

If you have additional questions that relate to COVID-19 please submit them to the provider relations email so that they are properly tracked. That email is DBHDD.Provider@DBHDD.GA.GOV

CC: Monica Johnson, Adrian Johnson, Terri Timberlake, Dante McKay, Jeff Minor, David Sofferin, Lynn Copeland, Melissa Sperbeck, Emile Risby



Georgia Department of Behavioral Health & Developmental Disabilities Judy Fitzgerald, Commissioner

TO: Addiction Recovery Support Centers

Peer Support Wellness and Respite Centers

FROM: Tony Sanchez, CDAC, CPS-AD, director of DBHDD's Office Recovery

Transformation

DATE: March 18, 2020

RE: Guidance for DBHDD Addiction Recovery Support Centers (ARSC) and

Peer Support Wellness and Respite Centers (PSWRC) during COVID-19

epidemic

In response to the coronavirus (COVID-19) in Georgia, and Governor Kemp's Public Health State of Emergency guidance to increase efforts related to social distancing, DBHDD is supporting techniques that allow the continuation of services virtually through our Addiction Recovery Support Centers (ARSC), Peer Support Wellness and Respite Centers (PSWRC). The health, safety, and well-being of the individuals we serve, and staff are DBHDD's top priority, and this decision has been made with those in mind. DBHDD is closely monitoring related developments and will provide additional information and updates related to ARSCs and PSWRCs in the coming weeks.

DBHDD has the expectation that all of our providers and their locations are open and able to serve their target populations. However, we realize that providers may need to adjust how they offer services considering the new guidelines from the federal government to limit all social gatherings to fewer than 10 people.

DBHDD appreciates the connectivity that our many peer centers have created within our communities and would like for our centers to stay connected during this time of need by:1

- Virtual recovery meetings
 - o Zoom, Go-to-Meeting, Web-ex
- Increased social media presence
 - Testimonial watch parties
 - o Regular posts with peer support contact numbers
 - Regular posts with contact numbers for other important community resources such as
 - Food banks, <u>CDC</u> and <u>Georgia DPH</u>
- Telephonic recovery coaching

Please be sure to regularly check the <u>CDC</u> and <u>Georgia DPH</u> websites for the most up-to-date information about COVID-19, and remember to be vigilant about personal hygiene.

If you have additional questions that relate to COVID-19, please submit them to the provider relations email, DBHDD.Provider@dbhdd.ga.gov, so that they can properly tracked.

Thank you for all that you do!

¹The supports provided by these recovery centers/supports are not medical treatment supports, so if there are no transactions of personal health information, these technologies can be used.



Judy Fitzgerald, Commissioner

D·B·H·D·D Office of Adult Mental Health

To: DBHDD-contracted providers of Mobile Crisis Response Service (MCRS)

From: Terri Timberlake, Ph.D., Director

Office of Adult Mental Health

Date: March 19, 2020

Re: COVID 19 guidance for MCRS

The current Coronavirus pandemic has sparked heightened health and safety concerns across our state. Our Department is hopeful that each provider is taking the recommended precautions to reasonably support the wellbeing of your staff. Similarly, we expect health and safety measures to be taken to support the needs of individuals seeking mobile crisis response services. This is a vulnerable, high need population and without necessary support, these individuals face increased risks. Below are responses to questions raised that will offer MCRS guidance for use solely for the period of crisis.

Q1: Can MCRS utilize only 1 responder when needing to make face to face contact instead of the required 2?

A1: This is allowed.

Q2: Can MCRS utilize telehealth when responding to jails and ER's? This would often include only audio by phone only to complete the assessments especially in the rural ER's.

A2: This is allowed with documented justification, intervention, recommendation and follow-up.

Q3: For Hospitals, MCRS would screen via phone and ensure that the teams have access to the ER. Some ER's do not want "non-medical" staff to enter right now.

A3: Video is preferred if available. Telephone with audio only is acceptable but should be used as last resort. If phone contact is used, these calls must be tracked via a document that they can be submitted to DBHDD along with follow up. For provision of MCRS in jails, request a meeting in the visitation area where there is a physical barrier. This will be allowed based on supervisors' decision, documentation, justification, intervention, recommendation and follow-up.

Q4: For provision of MCRS in group homes, if dispatching MCT, can a phone screen be done?

A4: Telephone screening to determine health risk (no symptoms, no confirmed positive COVID19 etc.) use contact precautions, then respond in person. If person is symptomatic, use video (preferred) or phone-audio as last resort.

The Georgia Department of Public Health (DPH) and the Centers for Disease Control and Prevention (CDC) websites contain the most up-to-date information that will help us take sensible steps and support our ability to make health promoting choices. Guidance for clinicians and those providing direct service to individuals can be found on the Georgia DPH website. DBHDD will continue to provide updates via the Provider Newsletter: Network News. Should you have questions, please submit them to our Provider Relations team via the Provider Issue Management System or submit an email to DBHDD.Provider@dbhdd.ga.gov

Please remember to be vigilant about hygiene practices.

cc: Jeff Minor, Chief Operating Officer

Monica Johnson, Director, Division of Behavioral Health Ron Wakefield Director, Division of Intellectual & Developmental Disabilities Lori Campbell, Assistant Director, Division of Intellectual & Developmental Disabilities

Adrian Johnson, Assistant Director, Division of Behavioral Health Dante` McKay, Director, Office of Children, Young Adults and Families Kimberly Briggs, Assistant Director, Office of Adult Mental Health Beth Shaw, Director, Office of Transitions Debbie Atkins, Director, Office of Crisis Coordination David Sofferin, Director, Office of Public Affairs



Judy Fitzgerald, Commissioner

D·B·H·D·D

Division of Behavioral Health

TO: **DBHDD Clubhouse Programs**

FROM: Danté McKay, JD, MPA

Director - Office of Children, Young Adults & Families

Jill Mays, MS, LPC

Director, Office of BH Prevention & Federal Grants

Cassandra Price, GCADC II, MBA Director, Office of Addictive Diseases

DATE: March 20, 2020

RE: Guidance for DBHDD Clubhouse Programs; CYF, AD & Prevention

In response to the coronavirus (COVID-19) in Georgia, and Governor Kemp's Public Health State of Emergency guidance to increase efforts related to social distancing, DBHDD is supporting techniques that allow the continuation of services virtually through our DBHDD Clubhouse Programs. The health, safety, and well-being of the individuals we serve, and staff are DBHDD's top priority, and this decision has been made with those in mind. DBHDD is closely monitoring related developments and will provide additional information and updates related to Clubhouses in the coming weeks.

DBHDD has the expectation that all providers and their locations are open and able to serve their target populations. However, we realize that providers may need to adjust how they offer services considering the new guidelines from the federal government to limit all social gatherings to fewer than 10 people.

DBHDD appreciates the connectivity that our many Clubhouses have created within our communities and would like for our Clubhouses to stay connected during this time of need by:1

- Virtual recovery, prevention and resiliency support meetings
 - o Zoom, Go-to-Meeting, Web-ex
- Increased social media presence
 - Testimonial watch parties
 - Online group activities
 - o Regular posts with peer support contact numbers
 - o Regular posts with contact numbers for other important community resources such as
 - Food banks, CDC and Georgia

- Telephonic recovery coaching
- One-on-one sessions

Please be sure to regularly check the <u>CDC</u> and <u>Georgia DPH</u> websites for the most up-to-date information about COVID-19, and remember to be vigilant about personal hygiene.

If you have additional questions that relate to COVID-19, please submit them to the provider relations email, <u>DBHDD.Provider@dbhdd.ga.gov</u>, so that they can be properly tracked.

Thank you for all that you do!

¹The supports provided by these Clubhouses are not medical treatment supports, so if there are no transactions of personal health information, these technologies can be used. However, clinical services provided by the CYF clubhouses should follow the DBHDD current telehealth guidance; https://files.constantcontact.com/c2257ded301/3e0220f3-4ccb-4a95-8451-dd05f672b14c.pdf

Cc: Monica Johnson Lynn Copeland David Sofferin Adrian Johnson



NOTICE: Georgia Crisis & Access Line

(#)

For access to services and immediate crisis help, call the <u>Georgia</u> <u>Crisis & Access Line (http://www.mygcal.com/)</u> (GCAL) at **1-800-715-4225**, available 24/7.

Coronavirus: COVID-19 Provider FAQs

Due to the recent developments with COVID-19 we have provided answers to the most asked provider questions. If you have a question that you do not see answered below please submit it via PIMS/Default.aspx). (https://dbhddapps.dbhdd.ga.gov/PIMS/Default.aspx).

What are the codes for Billing for telemedicine or telephonic billing?



Please reference the DBHDD Provider Bulletin released on March 19, 2020.

- Table A Services should be submitted with the GT service (ACT is the only exception where U1 and U2 practitioners have the GT modifier, but other practitioner level codes do not)
- \circ Table $\acute{\mathbf{B}}$ Services should consider the following:
 - If there is a UK modifier within that Service Definition defined as applicable to telephonic intervention, then submit the Code with that modifier AND the Place of Service code 02;

If there is no UK modifier, submit the service code as normal (considering the telemedicine/telephonic claims as "in-clinic"/U6), only add the 02 code in the Place of Service for the claim submission to MMIS.

Should we add the 95 Modifier for CPT codes in order to bill DCH for telemedicine?



No. The 95 modifier is not a recognized modifier affiliated with the DBHDD/Medicaid billable behavioral health codes. The addition of that modifier will yield a denial in the MMIS system.

Due to the allowance of the use telemedicine for certain services for precautionary measures, will there be any changes to the reimbursement rates for services? Or will Medicaid observe the Telehealth Site Visit code Q3014GT for Category of Service 44



There is currently no consideration of additional payment for telemedicine modality used in the provision of Community Behavioral Health Rehabilitation Services program through the Q – code-named above or through other mechanisms (as administrative costs such as telemedicine were considered and included in the reimbursement rate structure).

How is Telemedicine different from Telehealth/Telephonic service delivery?

^

Telemedicine is the use of medical information exchanged from one secured site to another via electronic communications to improve a patient's health. Electronic communication means the use of interactive telecommunications equipment that includes, at a minimum, audio and video equipment permitting two-way, real time interactive communication between the patient, and the physician or practitioner at the distant site (defined in the DBHDD Behavioral Health Provider Manual, Glossary). In response to COVID-19, Federal and State authorities are referencing the term "telehealth" which is a broad definition which encompasses phone, text, email, monitoring, and other modalities of interaction as being enabled. Very specifically, DBHDD and DCH are enabling some telemedicine and telephonic options on accordance with this Provider Bulletin. (https://files.constantcontact.com/c2257ded301/3e0220f3-4ccb-4a95-8451-ddo5f672b14c.pdf)

Will the DBHDD waive requirements of the Secretary of State related to the training requirements for LCSWs, LPCs, and LMFTs in order to provide these services (135-11)?



DBHDD is aware of the State of Georgia Rule and Regulation 135-11-01 and the rules governing Professional Counselors, Social Workers, and Marriage and Family Therapists on the use of a term called "telemental health." "Telemental health" is defined in the regulation as a mode of delivering services via technology-assisted media, such as but not limited to, a telephone, video, internet, a smartphone, tablet, PC desktop system or other electronic means using appropriate encryption technology for electronic health information. TeleMental Health facilitates client self-management and support for clients and includes synchronous interactions and asynchronous store and forward transfers. The regulation requires that any licensee has obtained a minimum of six (6) continuing education hours before providing "telemental health." Additionally, prior to the delivery of supervision via telemental health, the supervisor shall have obtained a minimum of nine (9) hours of continuing education to provide Supervision.

DBHDD heard your concerns regarding the continuing education requirements associated with telemental health and how the state regulations present a hindrance for some licensed staff who are eager to provide supports to individuals using telehealth functionality during this public health emergency. To support our providers and the individuals we serve, DBHDD approached the Georgia Board of Professional Counselors, Social Workers, and Marriage and Family Therapists to seek a waiver of the telemental health

continued education requirements through the duration of the COVID-19 pandemic. More specifically, we sought a waiver of the regulation that requires licensees to obtain at least 6 continuing education hours before providing telemental health and the regulation which requires supervisors to obtain at least 9 hours of continuing education before providing supervision.

We recently learned that the Board opted not to waive the requirements. Like you, we are disappointed with the Board's decision. The Board did vote, however, to allow all continuing education courses to be completed online. We urge all providers to abide by the regulations governing licensure. If additional continuing education is needed to deliver services, we request that providers work expeditiously to meet established requirements. Additional information regarding governing regulations can be found at the Secretary of State's website (https://sos.ga.gov/index.php/licensing/plb/43).

For new or renewed Individualized Recovery Plans, is it still a requirement for signatures?



The DBHDD will allow documentation of verbal agreement for an IRP via phone. The Progress Note shall clearly indicate that all typical content associated with a face-to-face process of delivering Service Plan Development was met, including the engagement with the individual served as a full partner in that process.

Can an individual consent to telemedicine via telemedicine or phone?



The DBHDD will allow documentation of verbal consent via telemedicine or phone. The required consent as defined in the DBHDD BH Provider Manual is designed and promulgated by the Department of Community Health. To access the Consent Form:

https://www.mmis.georgia.gov/portal/ (https://www.mmis.georgia.gov/portal/); then click Provider Information > Provider Manuals > Telemedicine Guidance. The documentation of the verbal consent in the progress note should include basic elements from the form in the absence of that signed document.

Can an individual consent to telemedicine via email?



The DBHDD will allow documentation of verbal consent via phone. Email consent would also be acceptable if the consent request is 1) sent through encrypted technology or 2) is generalist enough to transact without concern regarding HIPAA/42 CFR Part 2. To access the Consent Form: https://www.mmis.georgia.gov/portal/(https://www.mmis.georgia.gov/portal/); then click Provider Information > Provider Manuals > Telemedicine Guidance. The documentation of the verbal consent in the progress note should include basic elements from the form in the absence of that signed document.

Isn't it true that all tele-medicine has to be done from a facility-based distant site?

DBHDD does not constrict the "distant site" definition to be facility-based. All providers and their associated practitioners MUST be cognizant of HIPAA and 42CFR Part 2 regulation, considering the distant site security as well. Consider that having a Telemedicine session from a non-facility distant site (such as from a personal home with other family members within earshot) would not be permissible. Your agency must still comply with all state and federal laws related to security and confidentiality.

Does the DBHDD guidance in the Provider Bulletins apply to the CMOs?



The DCH Medicaid CMOs are not obligated to follow DBHDD guidance. The DCH and CMOs will set their specific provisions for service access (if any).



NETWORK BULLETIN



DBHDD Provides Sign Language Interpreters for Behavioral Health Services

Greetings from the Office of Deaf Services!

During this time of concern over COVID-19, the Office of Deaf Services wants to provide information to our provider network about accessing needed American Sign Language (ASL) interpreter supports. Now as always, DBHDD can provide interpreters to DBHDD-authorized providers, at no cost, to make sure that services are accessible to individuals who are deaf or hard of hearing.

Not all ASL interpreters are equally qualified to provide interpreting in behavioral health service settings. The Americans with Disabilities Act regulations require providers to use a "qualified interpreter," defined as "an interpreter who, via a video remote interpreting (VRI) service or an on-site appearance, is able to interpret effectively, accurately, and impartially, both receptively and expressively, using any necessary specialized vocabulary." DBHDD employs and contracts with a number of Qualified Mental Health Interpreters who have been specially trained to facilitate effective communication in ASL for individuals receiving behavioral health services.

Available In-Person ASL Interpreters

For individuals who are Deaf/hard of hearing and request sign language interpretation for their appointments, the Office of Deaf Services is still able to send Qualified Mental Health Interpreters to be present at the in-person appointments for the individual. For services that are going to be provided remotely (via telemedicine), a Qualified Mental Health Interpreter can be sent to be present with the clinician; the clinician and interpreter will place the call to the individual by videophone or other video conferencing technology.

Available Remote /VRI ASL Interpreters

Alternatively, the Office of Deaf Services is able to provide Qualified Mental Health Interpreter support through Video Remote Interpreting (VRI). The VRI interpreter can connect to the provider location via the phone; the individual receiving services and the interpreter would be able to interact via conferencing software called VSee (see below for more information on this software). This videoconferencing platform is encrypted and can be downloaded at provider locations to a laptop. This will allow the provider site to receive VRI support from the Office of Deaf Services. Additionally, if a service provider wishes to have the ability to see the individual receiving services, there is the capability to have a three-way interaction which would allow such interface.

In light of the recent communication from the U.S. Department of Health and Human Services regarding use of remote communication during the COVID-19 public health emergency, in some cases, providers might be connecting with individuals via a video chat application (for example, Apple FaceTime, Facebook Messenger video chat, Google Hangouts video, or Skype). In those cases, the Office of Deaf Services can also work with providers to coordinate interpreters to participate via those platforms. For these appointments, especially, please provide the Office of Deaf Services as much advance notice as possible, so that the details of the software/application and any technological and privacy questions can be worked out before the appointment.

What to Do

Case 1:16-cv-03088-ELR Document 448-73 Filed 11/29/23 Page 511 of 627 For DBHDD providers who need sign language interpreters for DBHDD services, please submit the request via the following protocol.

- 1. If the individual is new to your agency, please follow the notification and referral processes outlined in the DBHDD Policy "Provider Procedures for Referral and Reporting of Individuals with Hearing Loss, 15-111." Then proceed to step 2 below.
- 2. If you have previously served the individual and have already notified DBHDD of the individual, please follow the procedure and guidelines provided in the DBHDD Policy "Accessibility of Community Behavioral Health Services for Individuals Who are Deaf and Hard of Hearing, 15-114" (see especially Section C, "Booking An Interpreter"). You will receive a phone call or a follow-up email related to technology needs/preferences, and any questions that you have will be answered. Please allow as much lead time as possible in the scheduling of these interpreter appointments so that we may address any needs or concerns.

VSee

VSEE is an application that is free to download and use. The contact used is an email address. All of DBHDD's assigned interpreters who will be providing their services through VSee have a DBHDD email address. Once you have contacted the Office of Deaf Services, your interpreter contact email will be provided. For more information on Vsee, see https://vsee.com/.

We are very thankful for the work being done by the community provider network during this current crisis. We remain committed to the Deaf and hard of hearing individuals participating in DBHDD services, and want to promote access to these valuable services. If you have any additional questions, please review the DBHDD policies linked in this communication, and feel free to email DBHDD's Office of Deaf Services at deafservices@dbhdd.ga.gov.

Thank you!

Kelly Sterling, Director DBHDD Office of Deaf Services

Office of Provider Relations

Director

Lynn Copeland

Senior Provider Relations Manager

Carole Crowley

Provider Relations Managers

Sharon Pyles Tim Strickland Lisa Sweat



For Provider Relations inquiries, please contact us at DBHDD.Provider@dbhdd.ga.gov

BF WFI I



BE INFORMED

NETWORK BULLETIN



Continuing Education for Professional Counselors, Social Workers, and Marriage and Family Therapists

DBHDD is aware of the State of Georgia Rule and Regulation 135-11-.01 and the rules governing Professional Counselors, Social Workers, and Marriage and Family Therapists on the use of a term called "telemental health." "Telemental health" is defined in the regulation as a mode of delivering services via technology-assisted media, such as but not limited to, a telephone, video, internet, a smartphone, tablet, PC desktop system or other electronic means using appropriate encryption technology for electronic health information. TeleMental Health facilitates client self-management and support for clients and includes synchronous interactions and asynchronous store and forward transfers. The regulation requires that any licensee has obtained a minimum of six (6) continuing education hours before providing "telemental health." Additionally, prior to the delivery of supervision via telemental health, the supervisor shall have obtained a minimum of nine (9) hours of continuing education to provide Supervision.

DBHDD heard your concerns regarding the continuing education requirements associated with telemental health and how the state regulations present a hindrance for some licensed staff who are eager to provide supports to individuals using telehealth functionality during this public health emergency. To support our providers and the individuals we serve, DBHDD approached the Georgia Board of Professional Counselors, Social Workers, and Marriage and Family Therapists to seek waiver of the telemental health continued education requirements through the duration of the COVID-19 pandemic. More specifically, we sought waiver of the regulation that requires licensees to obtain at least 6 continuing education hours before providing telemental health and the regulation which requires supervisors to obtain at least 9 hours of continuing education before providing supervision.

We recently learned that the Board opted not to waive the requirements. Like you, we are disappointed with the Board's decision. The Board did vote, however, to allow all continuing education courses to be completed online. We urge all providers to abide by the regulations governing licensure. If additional continuing education is needed to deliver services, we request that providers work expeditiously to meet established requirements. Additional information regarding governing regulations can be found at the **Secretary of State's website**.

Thanks for all you do for the individuals and families receiving our services.

Submitted by:
Melissa Sperbeck
Director, Division of Performance Management and Quality Improvement

OFFICE OF HEALTH AND WELLNESS COVID 19 Fact Sheet and Health Care Plan

DBHDD's Office of Health and Wellness (OHW) has generated tools intended to offer providers quick (clinical) risk mitigation guidance when facing the impact of the current COVID 19 crisis. Created were a **COVID 19 fact sheet** and **healthcare plan** intended to

equip and remind providers of recommended actions to decrease the risk of infection and \$\particle{\partial}\text{presed1:16-cv-03088-ELR}\text{ Document 448-73}\text{ Filed 11/29/23}\text{ Page 513 of 627}

Additional access to these, and other, OHW tools are available on the **DBHDD website** by hovering over the "For Providers" tab and selecting "Improving Health Outcomes Initiative Collaborative Learning Center".

Providers electing to utilize the HRST web-based COVID 19 healthcare plan may do so through the established process for accessing all other HRST web-based healthcare plans.

Submitted by:
Dana N. Scott, MSN, RN
Director of Office of Health and Wellness
DBHDD Division of Developmental Disabilities

DBHDD Policy Information

Background Check Variance

Due to Covid-19, DBHDD understands that some fingerprinting sites have reduced hours or are closed. Therefore, during Georgia's Public Health State of Emergency, the "attestation" process set forth in the DBHDD policies below are in effect as stated therein.

COVID-19 2020: DBHDD Community Developmental Disability Services Policy Modifications - 3/26/2020

COVID-19 2020: DBHDD Community Behavioral Health Services Policy Modifications - 3/26/2020

POLICY REVISION

Payment by Individuals for Community Behavioral Health Services, 01-107

In the above mentioned policy related to state-funded behavioral health services, the provider is required to attempt to verify income using tax returns, pay check stubs, verification of benefits from other federal or state agencies.

For the period of the Public Health Emergency related to COVID-19, DBHDD waives the requirement for income verification to access state funded behavioral health services.

Provider agencies should request attestation of income from individuals served and verify to the best of their ability. If verification is unavailable due to resource constraints related to COVID-19, providers will note this in the record. At the end of the public health emergency, providers will need to verify individuals income status within 90 days.

Additional Resources

Substance Abuse and Mental Health Services Administration

The Substance Abuse and Mental Health Services Administration (SAMHSA) recognizes the

challenges posed by the current COVID-19 situation and is providing guidance and resources to assist: individuals and information and is providing guidance and resources to assist: individuals and information by clicking here.

PPE Use and Conservation - NETEC

The National Emerging Special Pathogen Training and Education Center (NETEC) has created a site on conservation of personal protective equipment (PPE). It has flyers, guides, videos and checklists. Please check this site regularly as additional materials will be added as guidance is updated. You can access this information by **clicking here**.

Office of Provider Relations

Director

Lynn Copeland

Senior Provider Relations Manager

Carole Crowley

Provider Relations Managers

Sharon Pyles Tim Strickland Lisa Sweat



For Provider Relations inquiries, please contact us at DBHDD.Provider@dbhdd.ga.gov

BE WELL







VERSION 1

COVID-19 2020: DBHDD Community Behavioral Health Services Policy Modifications

EFFECTIVE 3/26/2020

Current Status: Old PolicyStat ID: 7845537

Georgia Department of Behavioral Health & Developmental Disabilities Cowner: Monica Johnson MA J PC:

Owner: Monica Johnson, MA, LPC:

Director, Division of Behavioral

Health

Chapter: Admin Issues for BH & DD

Services

Sections:

COVID-19 2020: DBHDD Community Behavioral Health Services Policy Modifications - \square **/2** \square **/2020**

EFFECTIVE IMMEDIATELY

APPLICABILITY

DBHDD Providers of Community Behavioral Health Services

POLICY

In response to the continued transmission of COVID-19, where necessary new measures are in effect to minimize community spread of the virus, and to assist in the continued delivery of community behavioral health services.

Modifications as described in this policy refers to the restriction, enhancement, relaxation, and partial or full suspension of existing policies in PolicyStat, as applicable to the service. This policy includes full details of the alternate requirement(s) or procedures.

The following temporary modifications to the policies listed below are pertinent to community behavioral health services, effective immediately. Please refer to the full policy via the hyperlink, noting the alternate requirements applicable until further notice.

This policy will be updated as necessary. This policy remains in effect until the Governor of the State of Georgia lifts the Emergency Declaration.

- 1. A *partial suspension* of the fingerprinting requirement described in <u>Criminal History</u> Record Check for DBHDD Network Provider Applicants, 04-104 as follows:
 - a. DBHDD's Provider Network must have each person subject to Policy 04-104 complete the "Network Provider Applicant Attestation," Attachment A to this policy, instead of completing the fingerprint based background check stipulated in Policy 04-104.
 - b. Within thirty (30) days of cessation of the Public Health Emergency, all persons who signed the Network Provider Applicant Attestation instead of completing the fingerprint

based background check must complete a fingerprint based background check as required by Policy 04-104. The provider is responsible for sending any person who signed the Network Provider Applicant Attestation for a fingerprint based background check.

- c. The provider is also responsible for sending to DBHDD's Criminal History Background Check (CHBC) Section each signed Network Provider Applicant Attestation, while retaining a copy in the applicant's personnel file. The Individual Assessment process set forth in section D of Policy 04-104 does not apply to persons who sign the Network Provider Applicant Attestation.
- 2. A *partial suspension* of the fingerprinting requirement described in Criminal History Record Check for Individual Provider Applicants, 04-111 is permitted as follows:
 - a. All applicants who are subject to Policy 04-111 must complete the "Individual Provider Attestation," Attachment B to this policy, instead of completing the fingerprint based background check documented in Policy 04-111.
 - b. Within thirty (30) days of cessation of the Public Health Emergency, all applicants who signed the Individual Provider Attestation instead of completing the fingerprint based background check must complete a fingerprint based background check as required by Policy 04-111.
 - c. DBHDD Provider Enrollment is responsible for sending to DBHDD's Criminal History Background Check (CHBC) Section all signed Individual Provider Attestations. The Individual Assessment process set forth in Part D of Policy 04-111 does not apply to applicants who sign the Individual Provider Attestation.
- 3. A *partial suspension* of the income verification requirements using tax returns, pay check stubs, verification of benefits from other federal or state agencies as stipulated in Sections B.3 and F.2 of Payment by Individuals for Community Behavioral Health Services, 01-107 has been made as follows:
 - a. For the period of the Public Health Emergency related to COVID-19, DBHDD waives the requirement for income verification to access state funded behavioral health services.
 - b. Provider agencies are required to request attestation of income from individuals served and verify authenticity to the best of their ability.
 - i. If verification is unavailable due to resource constraints related to COVID-19, providers are required to note this in the record. At the end of the public health emergency, providers will be required to verify individuals income status within 90 days.

DBHDD sincerely appreciates your compliance with these measures throughout this Public Health Emergency.

Attachments

- A COVID-19 2020 Attestation of Absence of Barrier Crimes Data.docx
- B COVID-19 2020 Attestation of Absence of Barrier Crimes Data.docx

Approval Signatures

Approver	Date
Anne Akili, Psy.D.: Director, Policy Management	3/2 🗆 /2020
Monica Johnson, MA, LPC: Director, Division of Behavioral Health	3/2 🗆 /2020
Anne Akili, Psy.D.: Director, Policy Management	3/2 🗆 /2020





Georgia Department of Behavioral Health & Developmental Disabilities

Judy Fitzgerald, Commissioner

Office of Enterprise Compliance

Two Peachtree Street, NW • 1st Floor • Atlanta, Georgia 30303-3142 • Telephone: 404-463-2507 • Fax: 770-359-5473

I,					
	Last Name	First Nam	е	Middl	e Initial
	Social Security No.	Height	Weight	Eye color	Hair Color
	Date of Birth	Sex		Race	
	Street Address		City	State	Zip

attest that I have not been convicted of nor have pending charges for any crime listed on Barrier Record Data (Attachment D of <u>Criminal History Record Check for DBHDD</u> <u>Network Provider Applicants</u>, 04-104, a copy of which has been provided to me).

I also attest that:

- 1. I am not currently on probation as a First Offender for a crime listed on Barrier Record Data (Attachment D);
- 2. I am not awaiting final disposition on charges for any crime referenced on the Barrier Record Data (Attachment D);
- 3. I do not knowingly have an outstanding warrant for any crime referenced on the Barrier Record Data (Attachment D);
- 4. I do not have a finding of guilty but mentally ill (GBMI) for any crime referenced on the Barrier Record Data (Attachment D);
- 5. I do not have a finding of guilty with intellectual disability (GWID) for any crime referenced on the Barrier Record Data (Attachment D); and
- 6. I do not have a finding of not guilty by reason of insanity (NGRI) for any crime referenced on the Barrier Record Data (Attachment D).
- 7. I do not have any convictions within the last 12 months.

This form serves as a contingency for employment. Within 30 days of the termination of the Public Health State of Emergency, I understand that I will be required to complete a fingerprint based background check and if any information stated hereon is found to be falsified or untrue, I could be deemed ineligible for continued employment by a DBHDD network provider. I also understand that prior to being fingerprinted, if any information stated hereon is discovered to have been falsified or is found to be untrue, I could be deemed ineligible for continued employment.

Signature		
Date		



Georgia Department of Behavioral Health & Developmental Disabilities

Judy Fitzgerald, Commissioner

Last Name	First Name		Midd	le Initial	
Social Security No	Height	Weight	Eye color	Hair Color	
Date of Birth	Sex		Race		
Street Address		City	State	Zip	
3. I do not knowinglBarrier Record Da4. I do not have a fir	chment D); g final disposition or ta (Attachment D); y have an outstandir ta (Attachment D); dding of guilty but me	n charges for ng warrant fo entally ill (G	any crime refer	erenced on the	
5. I do not have a fir referenced on the	on the Barrier Record Data (Attachment D); 5. I do not have a finding of guilty with intellectual disability (GWID) for any crime referenced on the Barrier Record Data (Attachment D); and				
6. I do not have a finding of not guilty by reason of insanity (NGRI) for any crime referenced on the Barrier Record Data (Attachment D).7. I do not have any convictions within the last 12 months.					
This form serves as a conthe Public Health State of fingerprint based backgr falsified or untrue, I counderstand that prior to falsified or found to be un	of Emergency, I under ound check and if an ald be deemed inelig that time if it is dis	rstand that I ay informatio gible to be a scovered that	will be required on stated hereon on individual pro- t information st	d to complete a is found to be covider. I also cated hereon is	
		Signature			

2 Peachtree Street, NW • Atlanta, Georgia 30303 • 404.657.2252 dbhdd.georgia.gov • Facebook: Georgia DBHDD • Twitter: @DBHDD

Date

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Georgia Department of Behavioral Health & Developmental Disabilities

Judy Fitzgerald, Commissioner

D·B·H·D·D Division of Behavioral Health

To: All Regions and GHVP Providers

From: Office of Supportive Housing, DBHDD

Re: Temporary Measures to Address Tenant Loss of Income during COVID-19

Date: 3/27/2020

In response to the impact of the COVID-19 public health crisis the resultant disruption of local economies throughout the state and country, it is understood that GHVP recipients with employment may experience disruption in their income.

It is our shared mission to ensure the preservation of housing stability for these individuals. As a result we are making emergency accommodations in programmatic policy given the extenuating circumstances of the situation. These changes will remain in effect until further notice.

Individuals who lose their income and thus their ability to pay the tenant portion of the rent should not face termination from the program. Although county courts are not currently processing evictions, we wish to avoid the accumulation of destabilizing debt when the individual is unlikely to be able to resolve it without impacting other vital needs including utilities and food.

In order to fully address the loss of income, ALL individuals that identify a loss of income should be assisted by Providers with application for unemployment supports.

DBHDD will pay the total rent amount for individuals who lose their income as a result of COVID-19.

The Regional Field Office must submit a basic online form to the Central Office in order to adjust the payment amount on Beacon. Given the situation, we are not requesting the same level of documentation normally required for individuals with no income.

We are requesting an attestation from the Region that the loss of income has been reasonably verified by the Provider OR by Regional staff. A phone call or email from the employer to confirm is sufficient.

The change in payment amount will remain in effect until after the resolution of the crisis, at which point formal documentation will be required if the individual is to remain without income.

Clic here or copy the lin below:

https://forms.office.com/Pages/ResponsePage.aspx\(\text{id} \)\(\text{DaEtURsHIEu} \)\(\text{vJ7EBE0VFhWk} \)\(\text{gBy4} \)\(\text{h} \)\(\text{Ft} \)\(\text{cuOlz} \)\(\text{CN0PWcu} \)

For any questions regarding this form or policy change, please reach out to the Office of Supportive Housing.



Georgia Department of Behavioral Health & Developmental Disabilities

Judy Fitzgerald, Commissioner

Division of Behavioral Health

To: All Regions and GHVP Providers

From: Office of Supportive Housing, DBHDD

Re: Temporary Measures to Address Tenant Loss of Income during COVID-19

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In order to fully address the loss of income, ALL individuals that identify a loss of income should be assisted by Providers with application for unemployment supports.

DBHDD will pay the total rent amount for individuals who lose their income as a result of COVID-19.

In order to receive this emergency support, Providers must inform the Regional Field Office of the situation and help to verify the loss of income. The Region will submit a basic online form to the Central Office in order to request a temporary adjustment to the payment amount.

Given the situation, we are not requesting the same level of documentation normally required for individuals with no income. We are requiring attestation from the Region that the loss of income has been reasonably verified by the Provider OR by Regional staff. A phone call or email from the employer to confirm is sufficient.

The change in payment amount will remain in effect until after the resolution of the crisis, at which point formal documentation will be required if the individual is to remain without income.

For any questions regarding this form or policy change, please reach out to the Office of Supportive Housing.



Georgia Department of Behavioral Health & Developmental Disabilities

Judy Fitzgerald, Commissioner

Office of Adult Mental Health

MEMORANDUM

TO: DBHDD-Contracted Providers of AMH Supported Employment (SE)

FROM: Terri Timberlake, Ph.D., State Director

Office of Adult Mental Health

DATE: March 30, 2020

RE: Supported Employment Guidance during COVID-19 Response

The current Coronavirus pandemic has sparked heightened health and safety concerns across our state. DBHDD is hopeful that each provider is taking the recommended precautions to reasonably support the wellbeing of your staff. Similarly, we expect health and safety measures to be taken to support the needs of individuals engaged in supported employment services. As stated in correspondence distributed by Commissioner Judy Fitzgerald, all face-to-face contact requirements outlined in the DBHDD manual for supported employment services have been temporarily waived. Providers now have the flexibility to determine if it is safe to meet with individuals in person for billable services, or provide billable services via phone contact where it is more appropriate. Each region/provider encounters unique circumstances and removing the mandate to provide face-to-face contact allows providers the ability to make decisions that protect their staff and the individuals they serve. The following guidance is being provided to support your delivery of supported employment services.

Job Development

SE teams may continue to conduct job development in the community on behalf of individuals served, where feasible. Providers also have the option to contact employers via phone, or search for positions available online, to continue to provide job leads to SE-enrolled individuals. Please ensure appropriate documentation.

Billable Contact with SE-enrolled Individuals

Providers are encouraged to refer to the provider manual for SE-billable services for recommendations. However, SE providers can continue to develop jobs, provide job leads, provide support to working individuals via phone, communicate with employers via phone, assist in submitting applications online, provide feedback on résumé building, conduct mock interviews via phone, among other SE-billable tasks. Many of the services that employment specialists provide can continue to take place over the

phone, through video conferencing, and other means that providers can use to communicate with individuals served.

Questions and Information

The Georgia Department of Public Health (DPH) and the Centers for Disease Control and Prevention (CDC) websites contain the most up-to-date information that will help us take sensible steps and support our ability to make health promoting choices. Guidance for clinicians and those providing direct service to individuals can be found at www.dph.georgia.gov. DBHDD will continue to provide updates via the Provider Newsletter: Network News. Should you have questions, please submit them to our Provider Relations team via the Provider Issue Management System or submit an email to DBHDD.Provider@dbhdd.ga.gov.

Please remember to be vigilant about hygiene practices.

Thank you for your continued partnership.

Cc: Monica Johnson, Director, Division of Behavioral Health Kimberly Briggs, Assistant Director, Office of Adult Mental Health Vernell Jones, Program Manager, Office of Adult Mental Health **TO:** DBHDD Community-based Provider Network

FROM: Ron Wakefield, Division Director

Monica Johnson, Division Director

DATE: March 30, 2020

SUBJECT: COVID-19 Emergency - Staff Training Related to CPR and Crisis Intervention

In response to COVID-19 and the guidance of the Centers for Disease Control and Prevention (CDC), DBHDD Learning and many of the vendors with whom you work for training have eliminated certain trainings or the physical components of trainings. While we recognize the impact this decision has on staff development and readiness, we offer that it has been made with the health, safety and well-being of the individuals we serve, practitioners, and providers as the top priority. In light of this situation, DBHDD is modifying the current expectations related to certain staff prerequisites:

Provider Manual for Community Developmental Disability Providers				
Citation	Current Language	Modified Language		
PART II,	Training Requirements: Training records are to	Training Requirements: Training		
Section 2	be maintained, which document that all Crisis	records are to be maintained,		
Operational	Response System staff (in-home and out of	which document that all Crisis		
and Clinical	home) have participated in trainingand there	Response System staff (in-home		
Standards for	is documentation to demonstrate their	and out of home) have participated		
Georgia	competence in all crisis protocols and relevant	in trainingand there is		
Crisis	applicable trainings that includes but is not	documentation to demonstrate		
Response	limited to:	their competence in all crisis		
System	b. Mobile team members and intensive	protocols and relevant applicable		
(GCRS-	support staff are trained in protocols for:	trainings that includes but is not		
DD)F.5.b.iv.	iv. Required crisis intervention curriculum	limited to:		
	 Crisis Prevention Institute (CPI) 	b. Mobile team members and		
	www.crisisprevention.com	intensive support staff are		
	 Handle with Care Behavior 	trained in protocols for:		
	Management System, Inc.	iv. Completion of a crisis		
	www.handlewithcare.com	intervention curriculum		
	• Mindset	approved by DBHDD. The		
	http://interventionsupportservice.com	face-to-face or physical		
	Safe Crisis Management	certification elements are		
	www.jkmtraining.com	waived during the declared		
	• Safety- Care (QBS, Inc.)	COVID-19 response and the		
	www.qbscompanies.com	agency should plan for this		
	v. Cardiopulmonary Resuscitation (CPR)	type of training to be offered		
		to the staff within 60 days		
		from the official conclusion		
		of the State of Public Health		
		Emergency in Georgia.		
		v. Completion of an online CPR		
		training (with proficiency		

		T.
		deferred). The face-to-face or physical certification elements are waived during the declared COVID-19 response and the agency should plan for this type of training to be offered to the staff within 60 days from the official conclusion of the State of Public Health Emergency in Georgia.*
Part II, Section 3, Operational and Clinical Standards for Autism Spectrum Disorder Crisis Support Homes, P. 1. C.	Completion of a nationally recognized crisis intervention curriculum approved by DBHDD and taught by a certified trainer in such program as Crisis Prevention Institute (CPI);	Completion of a crisis intervention curriculum approved by DBHDD. The face-to-face or physical certification elements are waived during the declared COVID-19 response and the agency should plan for this type of training to be offered to the staff within 60 days from the official conclusion of the State of Public Health Emergency in Georgia.
Provider Manu	ial for Community Behavioral Health Providers	
Citation	Current Language	Modified Language
Citation Part II, Section II. 2.F.		Modified Language Within the first sixty (60) days from date of hire, all staff having direct contact with individuals shall receive the following training including, but not limited to:

	waived during the declared
	COVID-19 response and the
	agency should plan for this
	type of training to be offered
	within 60 days from the official
	conclusion of the State of
	Public Health Emergency in
	Georgia.*

With these proposed modifications, we want to direct your attention to the several online crisis intervention and verbal de-escalation courses available through the DBHDD Developmental Disabilities, Behavioral Health, and Paraprofessional Relias Libraries. The following courses can be accessed through your agency's Relias Supervisor. If you do not have a Relias Supervisor, have questions, or need assistance, please contact: relias@uga.edu.

IDD Library:

Crisis Intervention for Individuals with Developmental Disabilities-

https://ddlibrarydbhdd.training.reliaslearning.com/Learning/Catalog.aspx?CourseCode=REL-IDD-0-CIIDD Crisis Management-

 $\underline{https://ddlibrarydbhdd.training.reliaslearning.com/Learning/Catalog.aspx?CourseCode=REL-HHS-0-CM-V2$

De-escalating Hostile Clients-

 $\underline{https://ddlibrarydbhdd.training.reliaslearning.com/Learning/Catalog.aspx?CourseCode=REL-HHS-0-DHC-V2$

BH Library:

Deaf Crisis Services- 717656-

https://georgiamhad.training.reliaslearning.com/Learning/Catalog.aspx?CourseCode=717656

Communication Skills and Conflict Management for Paraprofessionals- REL-HHS-0-

CSCM- https://georgiamhad.training.reliaslearning.com/Learning/Catalog.aspx?CourseCode=REL-HHS-0-CSCM

De-escalating Hostile Clients - REL-HHS-0-DHC-V2 -

https://georgiamhad.training.reliaslearning.com/Learning/Catalog.aspx?CourseCode=REL-HHS-0-DHC-V2

Calming Children in Crisis - REL-HHS-CWLA

CCC- https://GeorgiaMHAD.training.reliaslearning.com/Learning/Catalog.aspx?CourseCode=REL-HHS-CWLA-CCC

Safety/Crisis & De-Escalation- CSH-Safety-004- No Direct Link Crisis Management- REL-HHS-0-CV-V2-https://georgiamhad.training.reliaslearning.com/Learning/Catalog.aspx?CourseCode=REL-HHS-0-CM-V2 Crisis Management for Paraprofessionals- EL-CRMP-PPBH-GA-

https://GeorgiaMHAD.training.reliaslearning.com/Learning/Catalog.aspx?CourseCode=EL-CRMP-PPBH-GA

Crisis Planning with Families- REL-HHS-0-CPF-V2-

 $\underline{\text{https://GeorgiaMHAD.training.reliaslearning.com/Learning/Catalog.aspx?CourseCode=REL-HHS-0-CPF-}\underline{V2}$

^{*} The American Heart Association (AHA) has presented guidelines on how to safely train for CPR/First Aid. If the staff will be working with a vulnerable individual, DBHDD encourages the provider to consider training as defined here in revised AHA guidelines such as providing a mannequin for each student, disinfecting equipment thoroughly and spacing the students in accordance with the CDC guidelines.

Recovery Library:

Deaf Crisis Services Training – 820194- https://gadbhdd.training.reliaslearning.com/Learning/Catalog.aspx?CourseCode=820194

C: Wendy White Tiegreen, Office of Medicaid Coordination Theodore Carter, Jr., Office of Human Resources & Learning

NETWORK BULLETIN



TWO IMPORTANT ANNOUNCEMENTS AND PUBLIC HEALTH UPDATES

Billing for Medicaid Telehealth for Behavioral Health Services

In previous guidance, DBHDD has directed providers to utilize the Place of Service (POS) Code "02" to indicate telehealth services when the "GT" modifier is not available for Medicaid claims

We have been alerted that Medicaid claims for behavioral health services with the POS Code "02" are being denied. DCH is currently working with DXC to correct this issue and expect resolution for new claims submissions beginning this week. Claims submitted for dates of service after March 17, 2020 with this error will be reprocessed.

COVID-19 Emergency - Staff Training Related to CPR and Crisis Intervention

In response to COVID-19 and the guidance of the Centers for Disease Control and Prevention (CDC), DBHDD Learning and many of the vendors with whom you work for training have eliminated certain trainings or the physical components of trainings. While we recognize the impact this decision has on staff development and readiness, we offer that it has been made with the health, safety and well-being of the individuals we serve, practitioners, and providers as the top priority. In light of this situation, DBHDD is modifying the current expectations related to certain staff prerequisites.

Please review the Provider Guidance Memo by clicking here.

Department of Public Health Announcements

PPE Resource Request Link and Follow Up

The Resource Request process for Personal Protective Equipment (PPE) assistance was streamlined as we notified you of in the Provider Relations Special Bulletin that was distributed on March 24, 2020.

Please understand that the Department of Public Health (DPH) requests to the federal stockpile is not able to be totally fulfilled and supplies are limited. Your request may be partially fulfilled, or requested amounts may be significantly lowered, per supply

availability. Continue to try to source materials through your supply chains.

Case 1:16-cv-03088-ELR Document 448-73 Filed 11/29/23 Page 530 of 627

Below is the link to submit the PPE Resource Request.

PPE RESOURCE REQUEST

DPH ask that you submit your forms by noon on the following days:

- Saturday for Tuesday deliveries
- · Monday for Thursday deliveries
- Wednesday for Saturday deliveries

For resource request follow up questions, please call the Warehouse at 404-852-0250.

Healthcare Worker Return to Work Guidance After COVID-19 Illness or Exposure

Click here to read guidance from the Department of Public Health (DPH) for assistance when making a decision regarding "returning to work" for healthcare personnel.

Office of Provider Relations

Director

Lynn Copeland

Senior Provider Relations Manager

Carole Crowley

Provider Relations Managers

Sharon Pyles Tim Strickland Lisa Sweat



For Provider Relations inquiries, please contact us at DBHDD.Provider@dbhdd.ga.gov

BE WELL





Georgia Department of Behavioral Health & Developmental Disabilities

Judy Fitzgerald, Commissioner

D·B·H·D·D Division of Behavioral Health

TO: Georgia Medicaid-Enrolled Opioid Treatment Programs

FROM: Office of Addictive Diseases

Office of Medicaid Coordination

DATE: April 1, 2020

SUBJECT: Medication Assisted Treatment Guidance for Take-Home Medication and

Telehealth

Background: The Department of Behavioral Health and Developmental Disabilities (DBHDD) Office of Addictive Diseases (OAD) is Georgia's State Opioid Treatment Authority (SOTA). As such, DBHDD's OAD collaborates with other agencies in developing guidelines for establishing and/or closing Medication Assisted Treatment (MAT) Programs operating in Georgia. As the SOTA, DBHDD is also responsible for establishing guidelines for the administration of MAT programs. In this capacity we are concerned with the continuity of care for all individuals currently enrolled in Opioid Treatment Programs in Georgia. Due to the current challenge of addressing COVID-19 in our state, we are providing additional guidance regarding take-home medication, telehealth, and billing for medication administration.

Guidance: In an effort to maintain patient continuity of care and respond to provider needs during the COVID-19 response, DBHDD has partnered with the Department of Community Health (DCH - Georgia's Medicaid authority) to consider special provisions for Opioid Treatment Programs enrolled to provide the Medication Assisted Treatment Package as defined by DBHDD in its Community Behavioral Health Provider Manual. For the period of the official declaration of State of Public Health Emergency in Georgia for COVID-19, telemedicine/telephonic supervision (video-enabled only) of the individual's self-administration of takehome medication will be allowed to be billed as either Medication Administration or Opioid Maintenance in accordance with those definitions. This is only for individuals receiving Opioid Maintenance treatment and who have been clinically allowed take-home medications due to the emergency. Documentation must include all checks of physical and mental responses/symptoms which would generally occur in a face-to-face intervention.

GENERAL REQUIRED COMPONENTS OF MEDICATION ADMINISTRATION TAKE-HOME WAIVER:

1. There must be a written service order for Medication Administration and a written order for the medication and the administration of the medication that complies with guidelines in Part II, Section 1, Subsection 6 - Medication of the Provider Manual.

- 2. The order for and administration of medication must be completed by members of the medical staff pursuant to the Medical Practice Act of 2009, Subsection 43-34-23 Delegation of Authority to Nurse and Physician Assistant.
- 3. The order must be in the individual's chart. Telephone/verbal orders are acceptable provided they are signed by an appropriate member of the medical staff in accordance with DBHDD requirements.
- 4. For the period of the official declaration of State of Public Health Emergency in Georgia for COVID-19, documentation must support the medical necessity of administration by licensed/credentialed medical personnel or support the clinically indicated/approved plan for take-home medication (either independently self-administered or with telemedicine/telephonic daily oversight of administration).
- 5. Documentation must support that the individual served is being trained in the risks and benefits of the medications being administered (or self-administered, if there is a clinically-approved takehome medication plan) and that symptoms are being monitored by the program staff who are either administering the medication, supervising the daily self-administration of take-home medication, or billing for check-ins with the individuals related to their daily self-administration plan.
- 6. If take-homes are being allowed in accordance with a clinically indicated plan, documentation must support that the individual is being trained in the principle of self-administration of medication or that the individual is physically or mentally unable to self-administer. Opioid Treatment Programs should implement procedures to monitor, recognize and manage patients, staff and visitors to their facility for the prevention of COVID-19.

TELEMEDICINE/TELEPHONIC PROVISIONS

DBHDD, in concert with the DCH, has released temporary <u>allowances</u> on the provision of services via telemedicine and telephonic modalities. As Medication Assisted Treatment (MAT) is a program service which is comprised of "unbundled," discrete services, this helpful table is included below:

MAT Discrete Service Interventions	Additional COVID-19 Response Modes of Delivery
Physician Assessment	Telemedicine/Telephonic
Nursing Assessment	Telemedicine/Telephonic
Medication Administration (Supervision of Self-administration)	Telemedicine/Telephonic (video-enabled only)
Opioid Maintenance (Supervision of Self-administration)	Telemedicine/Telephonic (video enabled only)
Diagnostic Assessment	Telemedicine/Telephonic
Individual Counseling	Telemedicine/Telephonic
Group Outpatient Services (including psycho-educational groups	Telemedicine/Telephonic
focusing on relapse prevention and recovery)	(maximum group size = 6)
Family Outpatient Services	Telemedicine/Telephonic
Addictive Disease Support Services	Telemedicine/Telephonic
Behavioral Health Assessment & Service Planning Development	Telemedicine/Telephonic
Medication	

MODIFIED COMMUNITY BEHAVIORAL HEALTH SERVICE DEFINITION:

In addition to the General Required Components waiver citations above, please note that there is a temporary adjustment to the <u>DBHDD Community Behavioral Health Provider Manual</u> – MAT requirements noted below (new content represented by red font). These allowances/expectations will be in place until April 30, 2020.

Service Definition Section	Existing DBHDD Provider Manual Requirement	Waiver through April 30, 2020
Required Components	2. The program provides structured treatment and therapeutic services, utilizing activity schedules as part of its operational method, i.e., plans or schedules of days or times of day for certain activities. 3. The program must be in operation at least 5 hours per	 2. The program provides structured treatment and therapeutic services, utilizing activity schedules as part of its operational method, i.e., plans or schedules of days or times of day for certain activities. These schedules may include use of telemedicine or other telehealth platforms for participants. 3. During the COVID-19 emergency response period, all required program staff must be
	day Monday - Friday and a minimum of 3 hours per day on Saturdays.	accessible, either in-person at the program site or via telemedicine/other telehealth platforms, at least 5 hours per day Monday - Friday and a minimum of 3 hours per day on Saturdays. During a portion of these days/hours, the program site must be fully operational for in-person interventions: At least two days per week, for a minimum of 3 hours on each day (any remaining required hours for a day may be offered via telemedicine). The following information must be
Required Components, continued		provided, in writing, to each individual enrolled in the program: a. Specific days and times when required staff will be physically present at the program site for intervention; b. Specific days and times when required staff will be available via telemedicine/telehealth; c. Clear, detailed information and instructions for accessing telemedicine/other telehealth platforms; d. Alternative contact information for key staff who will serve as points of contact outside of scheduled program operation times; and e. Emergency contact information.

	5. The program conducts random drug screening and uses the results of these tests for marking participant's progress toward goals and for service planning.	5. The program conducts random drug screening and uses the results of these tests for marking participant's progress toward goals and for service planning. During the COVID-19 emergency response period, random drug screening may be less frequent.
	6. This service must operate at an established site approved by DBHDD, DEA, SAMHSA, and DCH/HFR.	6. During the COVID-19 response period, this service may be delivered via telemedicine/other telehealth platforms within the parameters outlined in Required Components item #3. When delivered in-person, this service must operate from an established site approved by
Required	9. The program physician shall ensure that each individual voluntarily chooses MAT and that all relevant facts concerning the use of the opioid drug are clearly and adequately explained to the individual, and that each individual provides informed written consent to treatment.	DBHDD, DEA, SAMHSA, and DCH/HFR. 9. The program physician shall ensure that each individual voluntarily chooses MAT and that all relevant facts concerning the use of the opioid drug are clearly and adequately explained to the individual, and that each individual provides informed written or verbal consent to treatment.
Components, continued	10. A full medical examination and other tests must be completed by the program within 14 days of admission.	10. A full medical examination and other tests must be completed by the program within 14 days of admission. During the COVID-19 response, this can occur via telemedicine and other telehealth platforms.
		12. For the period of the COVID-19 emergency, telemedicine-based (i.e. video is required) supervision of self-administration for individuals receiving Opioid Maintenance treatment and who have been allowed takehome medications due to the emergency may be documented and billed as either Medication Administration or Opioid Maintenance in accordance with those definitions, including all checks of physical and mental responses/symptoms which would generally occur in a face-to-face intervention. 13. During the COVID-19 emergency response period, documentation must support the medical necessity of administration by licensed/credentialed medical personnel or support the clinically indicated/approved plan for take-home medication (either independently self-administered or with
		telemedicine/telephonic daily oversight of administration). a. Documentation must support that the individual served is being trained in the

		risks and benefits of the medications being
		administered (or self-administered, if
		there is a clinically-approved take-home
		medication plan) and that symptoms are
		being monitored by the program staff who
		are either administering the medication,
		supervising the daily self-administration of take-home medication, or billing for
		check-ins with the individuals related to
		their daily self-administration plan.
		b. If take-home medications are being
		allowed in accordance with a clinically
		indicated plan, documentation must
		support that the individual is being
		trained in the principle of self-
		administration of medication or that the
		individual is physically or mentally unable
	o. There must be at least one	to self-administer.
	2. There must be at least one independently	2. During the COVID-19 emergency response period, there must be at least one
	licensed/certified	independently licensed/certified
	practitioner, (CAC-II, CAC-I,	practitioner, (CAC-II, CAC-I, GCADC-II or -
	GCADC-II or -III, GCADC-I,	III, GCADC-I, CAS, MAC, CAADC, LPC,
	CAS, MAC, CAADC, LPC,	LCSW, or LMFT) physically present and
	LCSW, or LMFT) on-site at all	accessible during on-site operating
	times the service is in	days/times, regardless of the number of
	operation, regardless of the	individuals participating. A practitioner
Staffing	number of individuals	meeting these qualifications must also be
Requirements	participating.	accessible via telemedicine/other telehealth platforms at all other times when the service
		is in remote operation, regardless of the
		number of individuals participating.
	7. Programs shall ensure that	7. Programs shall ensure that appropriate
	appropriate nursing care is	nursing care is provided at all times the
	provided at all times the	program is in operation. During the COVID-
	program is in operation.	19 emergency response period, certain
		nursing services/care may be provided via
		telemedicine or other telehealth platforms, as clinically appropriate.
	f. Medication	f. Medication Administration & Opioid
	Administration & Opioid	Maintenance:
	Maintenance:	iv. During the COVID-19 emergency
		response period, directly observed and
		supervised self-administration of take-
		home MAT medication via telemedicine
		(i.e. video <u>required</u>) is allowable for
		individuals who would otherwise require medication administration, if clinically
		appropriate (i.e. individual is deemed
Clinical		capable of self-administration if given
Operations		training and if under direct
_		observation/supervision, and is not
		considered at risk for overdose). The
		medical necessity of supervised self-
		administration must be documented in

Clinical		the individual's clinical record prior to implementation of this allowance.
Operations, continued	h. Nursing Assessment: This service requires face-to-face contact with the individual to monitor, evaluate, assess, and/or carry out a physician's orders regarding the physical and/or psychological problems of the individual	h. Nursing Assessment: This service requires face-to-face contact (during the COVID-19 emergency response period, this may be in-person or via telemedicine/other telehealth platforms, as is clinically feasible and appropriate) with the individual to monitor, evaluate, assess, and/or carry out a physician's orders regarding the physical and/or psychological problems of the individual
Service Access	The program must be in operation at least 5 hours per day Monday- Friday and a minimum of 3 hours per day on Saturdays.	During the COVID-19 emergency response period, all required program staff must be accessible, either in-person at the program site or via telemedicine/other telehealth technology, at least 5 hours per day Monday - Friday and a minimum of 3 hours per day on Saturdays. During a portion of this time, the program site must be fully operational for inperson interventions: At least two days per week, for a minimum of 3 hours on each day (any remaining required hours for a day may be offered via telemedicine).

DBHDD's response to the State of Public Emergency for COVID-19 is continuously adapting based upon the needs of the community, the provider network, and most importantly, the people we mutually serve. Please know that as DBHDD receives more information about the needs of our state we will respond accordingly and keep you, our partners, well informed. For questions and further discussion please call 404-416-5225 or email Vonshurii.wrighten@dbhdd.ga.gov.



NETWORK BULLETIN



ONE IMPORTANT ANNOUNCEMENT AND TRAINING OPPORTUNITIES

Medication Assisted Treatment Guidance for Take-Home Medication and Telehealth

The Department of Behavioral Health and Developmental Disabilities (DBHDD) Office of Addictive Diseases (OAD) is Georgia's State Opioid Treatment Authority (SOTA). As such, DBHDD's OAD collaborates with other agencies in developing guidelines for establishing and/or closing Medication Assisted Treatment (MAT) Programs operating in Georgia. As the SOTA, DBHDD is also responsible for establishing guidelines for the administration of MAT programs. In this capacity we are concerned with the continuity of care for all individuals currently enrolled in Opioid Treatment Programs in Georgia. Due to the current challenge of addressing COVID-19 in our state, we are providing additional guidance regarding take-home medication, telehealth, and billing for medication administration.

In an effort to maintain patient continuity of care and respond to provider needs during the COVID-19 response, DBHDD has partnered with the Department of Community Health (DCH - Georgia's Medicaid authority) to consider special provisions for Opioid Treatment Programs enrolled to provide the Medication Assisted Treatment Package as defined by DBHDD in its Community Behavioral Health Provider Manual.

Please review the Provider Guidance Memo by clicking here

DBHDD Mental Health Wellness Resources

On behalf of the Department of Behavioral Health and Developmental Disabilities (DBHDD) and the hundreds of thousands of Georgians we serve, we want to thank you for your tireless efforts to provide services during these uncertain and rapidly changing times. Your work has always been vitally important to our public safety net, but in the last several weeks, you have demonstrated remarkable flexibility and adaptability in the name of making sure that some of Georgia's most vulnerable citizens are still able to receive high-quality care. We are grateful for your commitment and partnership.

We know that you are under great stress and working very hard to meet the needs of the people you serve while navigating a complex health care system. We also know that you have your own health needs – both mental and physical. We want to encourage you not to neglect your health while you are supporting the health of others. DBHDD is committed to supporting you and bolstering your mental strength so that you can keep serving those who need you.

To this end, we are standing up the following Mental Health Wellness resources:

• 2x2: Daily Self-Care Tips and Support for Health Care and Emergency Response

Workers (more information below)

Case Handouts 070 Beatth Pare Workers on the 48to Take Falce of 1.11/2008 Edves Plangre 5138 to 1627 available by clicking here and clicking here

 A warm line staffed by Georgia's peer workforce and individuals certified in Mental Health First Aid to offer support, general information, and wellness tips (coming next week)

We invite you to participate in our **2x2 Series: Daily Self-Care Tips and Support for Health Care and Emergency Response Workers**. These Webex events are designed to provide daily self-care tips and support for health care and emergency response workers. Each session will provide attendees with mental health tips about managing stress, grief, work/life balance, and wellness. The series will held on weekdays at 2:00 p.m.

NOTE: This session will utilize the WebEx webinar online conferencing system. WebEx allows participants to log on to a website from their computer and view the facilitator's information online, while listening to the facilitator through the use of a simultaneous telephone conference call.

All participants must use the link below to register for the 2x2 series. Additionally, please note that it is strongly encouraged that you join the webinar 10-15 minutes prior to the start time to ensure that you do not experience any connectivity issues. Although all attendees will be muted, the chat box will be functional, and all attendees are encouraged to ask questions and share thoughts through the interactive chat. The facilitator will allot time for Q&A at the end of the presentation.

Below is the date, time, session title and registration link for the April 3 session:

April 3, 2020, 2:00 to 2:30 p.m. Conflict and Crisis Management

If you cannot attend the live session, it will be recorded and available for review on the DBHDD website **here**.

For questions about the webinar, please email **DBHDDLearning@dbhdd.ga.gov**.

We also encourage you to look to trusted resources for managing stress and anxiety amid the COVID-19 crisis, such as these:

https://www.psychiatry.org/psychiatrists/covid-19-coronavirus https://www.cdc.gov/coronavirus/2019-ncov/prepare/managing-stress-anxiety.html

As you continue to support Georgians with mental health challenges, substance use disorders, and intellectual and developmental disabilities, please know that we are with you. Thank you for everything you do on behalf of the people we serve.

Telehealth Learning and Consultation (TLC) Tuesdays

TELEHEALTH LEARNING & CONSULTATION (TLC)
TUESDAYS
9-10 a.m. MT/10-11 a.m. CT ◀



The Southeast Mental Health Technology Transfer Center (MHTTC) agency, associated with the Substance Abuse and Mental Health Administration (SAMHSA), is offering an online series designed to support providers in utilizing telehealth services. Please join them for Telehealth Learning and Consultation (TLC) Tuesdays, an online series for providers who are new to or unfamiliar with telehealth.

These will occur from 11 am - 12 pm Eastern Standard Time Tuesday through April.

During each hour-long session, the Technology Transfer Center (TTC) Network specialists will spend 20 minutes addressing a specific topic, then answer questions submitted by TLC Tuesday registrants. Recordings of the 20-minute presentations, as well as additional resources, will be posted on the **web page** as they become available.

Formust Georgister Separately for each one of the dates below. With the submit any questions you might have. Register by clicking one of the dates below. Certificates of completion will be available.

March 31: Telehealth Basics
April 7: Telehealth Billing
April 14: Telehealth Tools
April 21: Telehealth with Children and Adolescents

April 28: Telehealth Troubleshooting

Office of Provider Relations

Director

Lynn Copeland

Senior Provider Relations Manager

Carole Crowley

Provider Relations Managers

Sharon Pyles Tim Strickland Lisa Sweat



For Provider Relations inquiries, please contact us at DBHDD.Provider@dbhdd.ga.gov

BE WELL





SUMMARY OF COVID-19 POLICY MODIFICATIONS

PERIOD COVERED - MARCH 26, 2020 TO APRIL 23, 2020

This summary of modifications is designed to guide the review of new and revised content published at https://gadbhdd.policystat.com as it relates to each iteration of the COVID-19 2020; DBHDD Community Behavioral Health Services Policy Modifications policy. This policy was instated during the COVID-19 coronavirus pandemic, while the State of Georgia declared a Public Health Emergency.

The responsibility for thorough review of the policy content remains with the Provider.

Policy Date	Policy Item #	Original Policy Impacted by the Modification	Summary of Modification
	1.	Criminal History Record Check for Individual Provider Applicants, 04-111	Partial suspension of fingerprinting requirements, including a one-page attestation - Attachment A.
3/26/2020	2.	Criminal History Record Check for Individual Provider Applicants, 04-111	Partial suspension of fingerprinting requirements, including a one-page attestation - Attachment B.
	33	Payment by Individuals for Community Behavioral Health Services, 01-107	Partial suspension of the income verification requirements.
00007	1.	Criminal History Record Check for DBHDD Network Provider Applicants, 04-104	Additional language added to Section 1 items c and d, and new two page Attachment A added.
4/2/2020	2.	Criminal History Record Check for Individual Provider Applicants, 04-111	Additional language added to Section 2 items c and d, and new two-page Attachment B added.
4/8/2020	1.	Recruitment and Application to become a Provider of Behavioral Health Services, 01-111	Temporary suspension of the site visit requirement for behavioral health provider enrollment, Section 1 items a and b. Notification of the impact of non-attendance at Applicant Forum, Section 1 item c.
	2.	Criminal History Record Check for DBHDD Network Provider Applicants, 04-104	Period of time allowed for fingerprinting increased from 30 days to 60 days. Revised Attachment A.
4/23/2020	3.	<u>Criminal History Record Check for Individual</u> <u>Provider Applicants, 04-111</u>	Removal of this policy reference because it is not applicable to BH providers.





VERSION 2

COVID-19 2020: DBHDD Community Behavioral Health Services Policy Modifications

EFFECTIVE 4/2/2020

Current Status: Old PolicyStat ID: 7872870

Georgia Department of Behavioral Health & Developmental Disabilities Cowner: Monica Johnson MA J. P.C.

Owner: Monica Johnson, MA, LPC:

Director, Division of Behavioral

Health

Chapter: Admin Issues for BH & DD

Services

Sections:

COVID-19 2020: DBHDD Community Behavioral Health Services Policy Modifications - 4/2/2020

EFFECTIVE IMMEDIATELY

APPLICABILITY

DBHDD Providers of Community Behavioral Health Services

POLICY

In response to the continued transmission of COVID-19, where necessary new measures are in effect to minimize community spread of the virus, and to assist in the continued delivery of community behavioral health services.

Modifications as described in this policy refers to the restriction, enhancement, relaxation, and partial or full suspension of existing policies in PolicyStat, as applicable to the service. This policy includes full details of the alternate requirement(s) or procedures.

The following temporary modifications to the policies listed below are pertinent to community behavioral health services, effective immediately. Please refer to the full policy via the hyperlink, noting the alternate requirements applicable until further notice.

This policy will be updated as necessary. This policy remains in effect until the Governor of the State of Georgia lifts the Emergency Declaration.

- 1. A *partial suspension* of the fingerprinting requirement described in <u>Criminal History</u> Record Check for DBHDD Network Provider Applicants, 04-104 as follows:
 - a. DBHDD's Provider Network must have each person subject to Policy 04-104 complete the "Network Provider Applicant Attestation," Attachment A to this policy, instead of completing the fingerprint based background check stipulated in Policy 04-104.
 - b. Within thirty (30) days of cessation of the Public Health Emergency, all persons who signed the Network Provider Applicant Attestation instead of completing the fingerprint

- based background check must complete a fingerprint based background check as required by Policy 04-104. The provider is responsible for sending any person who signed the Network Provider Applicant Attestation for a fingerprint based background check.
- c. The provider is also responsible for sending to DBHDD's Criminal History Background Check (CHBC) section each signed Network Provider Applicant Attestation, while retaining a copy in the applicant's personnel file. The provider must send the signed and dated Attestation to CHBC, and acknowledge receipt of an email from CHBC confirming acceptance of the Attestation, before the applicant begins working. The Individual Assessment process set forth in section D of Policy 04-104 does not apply to persons who sign the Network Provider Applicant Attestation.
- d. The Attestation cannot be used by Network Provider Applicants who were fingerprinted for a fingerprint- based background check within 30 days prior to the declaration of the Public Health Emergency.
- 2. A *partial suspension* of the fingerprinting requirement described in Criminal History Record Check for Individual Provider Applicants, 04-111 is permitted as follows:
 - a. All applicants who are subject to Policy 04-111 must complete the "Individual Provider Attestation," Attachment B to this policy, instead of completing the fingerprint based background check documented in Policy 04-111.
 - b. Within thirty (30) days of cessation of the Public Health Emergency, all applicants who signed the Individual Provider Attestation instead of completing the fingerprint based background check must complete a fingerprint based background check as required by Policy 04-111.
 - c. DBHDD Provider Enrollment is responsible for sending to DBHDD's Criminal History Background Check (CHBC) section all signed Individual Provider Attestations and for acknowledging receipt of an email from CHBC confirming acceptance of the Attestation, before the Individual Provider Applicant can be considered eligible. The Individual Assessment process set forth in Part D of Policy 04-111 does not apply to applicants who sign the Individual Provider Attestation.
 - d. The Attestation cannot be used by Individual Provider Applicants who were fingerprinted for a fingerprint based background check within 30 days prior to the declaration of the Public Health Emergency.
- 3. A *partial suspension* of the income verification requirements using tax returns, pay check stubs, verification of benefits from other federal or state agencies as stipulated in Sections B.3 and F.2 of Payment by Individuals for Community Behavioral Health Services, 01-107 has been made as follows:
 - a. For the period of the Public Health Emergency related to COVID-19, DBHDD waives the requirement for income verification to access state funded behavioral health services.
 - b. Provider agencies are required to request attestation of income from individuals served and verify authenticity to the best of their ability.
 - i. If verification is unavailable due to resource constraints related to COVID-19, providers are required to note this in the record. At the end of the public health

emergency, providers will be required to verify individuals income status within 90 days.

DBHDD sincerely appreciates your compliance with these measures throughout this Public Health Emergency.

Attachments

- A COVID-19 2020 Attestation of Absence of Barrier Crimes Data & Cover Letter.docx
- B COVID-19 2020 Attestation of Absence of Barrier Crimes Data & Cover Letter.docx

Approval Signatures

Approver	Date
Anne Akili, Psy.D.: Director, Policy Management	4/2/2020
Monica Johnson, MA, LPC: Director, Division of Behavioral Health	4/2/2020
Anne Akili, Psy.D.: Director, Policy Management	4/2/2020



Judy Fitzgerald, Commissioner

Office of Enterprise Compliance

Two Peachtree Street, NW • 1st Floor • Atlanta, Georgia 30303-3142 • Telephone: 404-463-2507 • Fax: 770-359-5473

I,					
, —	Last Name	First Nam	e	Midd	le Initial
	Social Security No.	Height	Weight	Eye color	Hair Color
	Date of Birth	Sex		Race	
	Street Address		City	State	Zip

attest that I have not been convicted of nor have pending charges for any crime listed on Barrier Record Data (Attachment D of <u>Criminal History Record Check for DBHDD</u> <u>Network Provider Applicants</u>, 04-104, a copy of which has been provided to me).

I also attest that:

- 1. I am not currently on probation as a First Offender for a crime listed on Barrier Record Data (Attachment D);
- 2. I am not awaiting final disposition on charges for any crime referenced on the Barrier Record Data (Attachment D);
- 3. I do not knowingly have an outstanding warrant for any crime referenced on the Barrier Record Data (Attachment D);
- 4. I do not have a finding of guilty but mentally ill (GBMI) for any crime referenced on the Barrier Record Data (Attachment D);
- 5. I do not have a finding of guilty with intellectual disability (GWID) for any crime referenced on the Barrier Record Data (Attachment D); and
- 6. I do not have a finding of not guilty by reason of insanity (NGRI) for any crime referenced on the Barrier Record Data (Attachment D).
- 7. I do not have any convictions within the last 12 months.

This form serves as a contingency for employment. Within 30 days of the termination of the Public Health State of Emergency, I understand that I will be required to complete a fingerprint based background check and if any information stated hereon is found to be falsified or untrue, I could be deemed ineligible for continued employment by a DBHDD network provider. I also understand that prior to being fingerprinted, if any information stated hereon is discovered to have been falsified or is found to be untrue, I could be deemed ineligible for continued employment.

Signature		
Date		



Judy Fitzgerald, Commissioner

Office of Enterprise Compliance

Two Peachtree Street, NW • 1st Floor • Atlanta, Georgia 30303-3142 • Telephone: 404-463-2507 • Fax: 770-359-5473

TO: DBHDD Provider Network

FROM: DBHDD Office of Enterprise Compliance

RE: Policy No. 04-104 Attestation

Immediately after a person subject to Policy No. 04-104, as modified during the Public Health State of Emergency, completes the Attestation required under the modified policy, send the Attestation to CHBC by facsimile to (770) 359-1622, or via email at **DBHDD-CRS@DBHDD.GA.GOV.** with this Cover Sheet after completing the information required below:

Provider Name	_			
Name of Direct Contact	_			
Contact Phone Number	_			
Email address				

Criminal History Background Checks Section

If you have questions, please contact our office at 404-463-2507 or 404-232-1641.



Judy Fitzgerald, Commissioner

Office of Enterprise Compliance

Two Peachtree Street, NW • 1st Floor • Atlanta, Georgia 30303-3142 • Telephone: 404-463-2507 • Fax: 770-359-5473

	First Name	e	Middl	e Initial
Social Security No.	Height	Weight	Eye color	Hair Color
Date of Birth	Sex		Race	
Street Address		City	State	Zip
 I also attest that: I am not currently on Record Data (Attachmete) I am not awaiting finate I am not awaiting finate Barrier Record Data (Attachmete) I do not knowingly have Barrier Record Data (Attachmete) I do not have a finding 	ent D); al disposition of attachment D); we an outstanditachment D); of guilty but no Data (Attachme	n charges for ng warrant fo nentally ill (GI	any crime refer any crime refe	erenced on the

Signature

Date

understand that prior to that time if it is discovered that information stated hereon is falsified or found to be untrue, I could be deemed ineligible to be an individual provider.



Judy Fitzgerald, Commissioner

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Judy Fitzgerald, Commissioner

Division of Behavioral Health

To: All Regions and DBHDD-Contracted Providers with Housing Outreach Coordinators

From: Maxwell Ruppersburg, Director, Office of Supportive Housing, DBHDD

Date: April 3, 2020

Re: Guidance for Housing Outreach Coordinators during COVID-19

In response to the statewide Shelter in Place order and Public Health State of Emergency in Georgia as a result of COVID-19, as well as the increasing pressures placed on the homeless and behavioral health system across the state, DBHDD and the Office of Supportive Housing is authorizing temporary programmatic changes, including guidance for Housing Outreach Coordinators, until further notice.

Currently in effect, all NSH referrals, upon approval, will receive a Notice to Proceed for GHVP and are not being asked to apply first for alternative resources. We are also making additional programmatic accommodations to support individuals during this crisis and those will continue to evolve.

During this time, we know that standard HOC outreach activity must change and adapt as a result of limited access to facilities and the cessation of community meetings. It is critical that HOCs continue to remain active so that we can continue to connect individuals to housing and keep them housed.

In response to this situation, we are asking that HOCs focus their time to support the priorities below.

Housing Outreach Coordinators should prioritize the following activities in this period:

- 1. Assisting with annual lease renewals to keep individuals stably housed.
- 2. Providing NSH assessment surveys and completion of referrals.
- 3. Identifying housing opportunities in the community and assist with housing search and leasing.

In addition to the above priorities, please continue with the following:

- 4. Review completed NSH surveys and close out the referrals, as needed. Follow up with individuals with a completed NSH intake who are not yet connected to services and/or supportive housing.
- □ Continue to communicate regularly with your Regional Field Office and the Central Office to relay any questions you have or challenges being experienced.
- □ Continue conducting calls and following up with assigned medical and correctional facilities.
- 7. Provide assistance at outpatient clinics and/or crisis centers to facilitate services for homeless individuals.
- 8. Participate in COVID-19 related and other learning opportunities via conference calls and webinars.
- 9. Coordinate resources with the PATH team in your area.
- 10. Make contact with the local homeless Continuum of Care to stay aware of resources and collaborations in the local area.
- 11. Make contact with the DCS regional coordinator for coordination of cases for individuals on supervision.

Please continue to exercise personal caution and recommended physical distancing, regular handwashing, and hygiene practices to safeguard the health of yourself and those around you. The work of Housing Outreach Coordinators and the provider network remains critical and ever needed during this time of crisis for so many around the state.

DBHDD Commissioner Judy Fitzgerald has issued a <u>letter of exemption</u> stating that the Governor's Shelter in Place order does not apply to DBHDD essential services which includes Housing Outreach Coordinators. This letter is not required by law but was requested by some providers and can be utilized if needed.

Please be sure to regularly check the <u>CDC</u> and <u>Georgia DPH</u> websites for the most up-to-date information about COVID-19 and remember to be vigilant about personal hygiene.

If you have additional questions that relate to COVID-19 please submit them to the provider relations email so that they are properly tracked. That email is DBHDD.BA.GOV

We appreciate everything you do □

CC:

Monica Johnson, Director, Division of Behavioral Health Adrian Johnson, Assistant Director, Division of Behavioral Health Letitia Robinson, Assistant Director, Office of Supportive Housing

Regional Housing Transition Coordinators Contact Information

Region	Name	Email
1	Scarlett Freelin	scarlett.freelin@dbhdd.ga.gov
2	April Edwards	april.edwards@dbhdd.ga.gov
3	Jamie □imbrough	jamie.kimbrough@dbhdd.ga.gov
4	Rachael Holloway	rachael.holloman@dbhdd.ga.gov
	Jeannette Bacon	Jeannette.Bacon@dbhdd.ga.gov
	Sam Page	Sam.Page@dbhdd.ga.gov

Housing Outreach Coordinator Contact Information

Region	First Name	Last Name	Agency	Email
1	Anita	Ojeda	Avita	Anita.Ojeda@avitapartners.org
1	Lee	Greene	Highland Rivers Health	dannygreene@highlandrivers.org
2	Lena	Mason	Advantage Behavioral Health Systems	lmason@advantagebhs.org
2	Marsha	Body	River Edge Behavioral Health Center	Mbody@river-edge.org
3	Cherealla	Lavan	De□alb CSB	clavan@dekcsb.org
3	Venessa	Bullard-Carr	View Point Health	Venessa.Bullard-Carr@VPHealth.org
4	Ginger	Eady	Aspire Behavioral Health	geady@albanycsb.org
4	Jeff	Hall	Legacy	jhall@bhsga.com
	Angie	Wright	CSB of Middle Georgia	adwright@csbmg.com
	Denean	Bonds	Gateway BHS	denean.bonds@gatewaybhs.org
	Janis	Jones	New Horizons Behavioral Health	jjones@nhbh.org



Judy Fitzgerald, Commissioner

D'B'H'D'D Division of Behavioral Health

To: DBHDD Contracted providers of Adult Mental Health and Addictive Diseases

Residential Services

From: Terri Timberlake, Ph.D., Director, Office of Adult Mental Health

Cassandra Price, Director, Office of Addictive Diseases

Date: 4/3/2020

Re: COVID-19 related operational guidance

The current Coronavirus pandemic has sparked heightened health and safety concerns across our state. Our Department is hopeful that each provider is taking the recommended precautions to reasonably support the wellbeing of your staff. Similarly, we expect health and safety measures to be taken to support the needs of individuals in community adult mental health and addictive diseases residential services. The individuals residing in residential services are a vulnerable, high need population and without necessary support, these individuals face increased risks.

The DBHDD has adopted general guidance for all residential facilities as outlined by the National Council for Behavioral Health (see attached) COVID-19 Guidance, please read the entire publication. Providers are strongly encouraged to follow additional guidelines from the Centers for Disease Control (CDC) and the Georgia Department of Public Health (GDPH). Special allowances that were detailed in the DBHDD COVID-19 Provider Relations Special Bulletin dated March 24, 2020 should also be reviewed. Further, any changes made by providers to residential capacity/ admission standards should be reported to the appropriate DBHDD office immediately and positive cases must be promptly reported through IMAGE system.

The CDC and state health departments have issued guidelines for health care workers who have tested positive or who have been in contact with a COVID-19 positive person, which include less stringent quarantine and return to work criteria for workers in times of shortage. These guidelines should be considered if the program experiences significant staff shortages.

Behavioral health residential facilities/settings should implement the following additional efforts to protect clients and staff in these programs:

- 1. Facilities should post educational information from official health sources throughout the building, including signage on how to properly wash your hands, signs and symptoms of early detection and outdoor signage to halt visitors or inform health care workers of access restrictions. Tools can be found on the CDC website.
- 2. Individuals should be educated to stay in the residence as much as possible. If they do go out, they should keep a distance of at least 6 feet away from anyone else, including relatives who do

not live in the residence, and avoid touching their faces. Programs should cancel all planned social or recreational outings. Upon returning home, everyone should immediately wash their hands with soap and water for at least 20 seconds or use an alcohol-based hand sanitizer. Cell phones and other frequently handled items should be sanitized daily.

Visitors

- 1. Residential settings/facilities should restrict visitation of all nonresidents (visitors and non-essential health care personnel) unless it is deemed necessary to directly support a resident's health and wellness or for certain compassionate care situations, such as young children in residential treatment or end- of-life care. In those cases, visitors should be limited to only a specific room. Facilities are expected to notify potential visitors to defer visitation until further notice through the facilities' websites, door signage, calls to family members, letters, etc. Note: If a state implements actions that exceed CMS requirements, such as a ban on all visitation through a governor's executive order, a facility would not be out of compliance with CMS' requirements.
- 2. Prior to entering the residence, all visitors should sanitize their hands and should be asked if they have a recent cough, sore throat, shortness of breath, fever or if they recently traveled on an airplane or on a cruise. If the response of any of these questions is "yes", the visitor should not be allowed into the residence.
- 3. For individuals who enter for compassionate situations meriting exceptions, facilities should require visitors to perform hand hygiene and use personal protective equipment (PPE), such as facemasks and gloves. Decisions about visitation during a compassionate exemption situation should be made on a case-by-case basis, which should include careful screening of the potential visitor for fever or respiratory symptoms or travel by airplane or cruise. Potential visitors with symptoms of a respiratory infection such as fever, cough, shortness of breath or sore throat, or recent airplane or cruise travel should not be permitted to enter the facility at any time, even in end-of-life situations. Visitors who are permitted, must wear a facemask while in the building and restrict their visit to the resident's room or other location(s) designated by the facility. They should also be reminded and monitored to frequently perform hand hygiene.

Staff

1. Staff should implement active screening and monitoring of residents and staff for fever and respiratory symptoms. Advise employees to check for any signs of illness before reporting to work each day and notify their supervisor if they become ill. Facilities may consider screening staff daily for fever or respiratory symptoms before entering the facility; when doing so, actively take their temperature and document absence of shortness of breath, cough or sore throat. If they are ill, have them put on a facemask and self-isolate at home for 14 days. Staff members should stay home if they are sick. Staff members who have had direct contact with individuals who test positive for COVID-19 or who are designated a person under investigation (PUI) should self-quarantine for 14 days and not come to the residential program and report symptoms to their supervisor. If, after 14 days following the last contact, they have not developed symptoms, they may return to work.

- 2. Facilities should identify staff who work at multiple facilities, including agency staff, regional or corporate staff, etc., and actively screen and restrict them appropriately to ensure that they do not place individuals in multiple facilities at risk for COVID-19.
- 3. Staff should review and revise how they interact with vendors and receive supplies. Incorporation of CDC contact precautions is necessary to prevent any potential transmission for agency staff when interacting with emergency medical services (EMS) personnel and equipment, food delivery, transporting residents to offsite appointments. For example, do not have supply vendors transport supplies inside the facility; supplies should be dropped off at a dedicated location and sanitized before entering the facility/residence.
- 4. Staff /residential facilities are advised to increase janitorial service at all public access points throughout the facility.

General Program guidance

- 1. To the extent possible, staff should work with clients' health care providers to institute telemedicine appointments
- 2. CDC guidance currently recommends suspending all groups and activities with more than 10 people. Communal dining and all group activities with more than 10 people, such as internal and external group activities, should be canceled.
- 3. Residential programs should utilize non-face-to-face meeting options, such as phone, video communications, etc., to the extent possible.
- 5. In shared bedrooms for individuals who have not developed symptoms, ensure that beds are at least 6 feet apart when possible and require that clients sleep head-to-toe.
- 6. Review CDC guidance for Interim Infection Prevention and Control Recommendations for Patients with Confirmed Coronavirus Disease 2019.
- 7. Increase the availability and accessibility of alcohol-based hand rubs (ABHR), reinforce strong hand-hygiene practices, tissues, no-touch receptacles for disposal, and facemasks at health care facility entrances, waiting rooms, resident check-ins, etc.
- 8. Ensure ABHR is accessible in all resident-care areas including inside and outside resident rooms.
- 9. Increase signage for vigilant infection prevention, such as hand hygiene and cough etiquette.

Accepting New Admissions

It is important for individuals with mental health and substance use conditions to participate in necessary services even during this crisis. Residential programs should continue accepting new client referrals if able to meet the following conditions:

- 1. Have space/capacity to isolate new residents for 14 day,
- 2. Have the necessary PPE equipment for staff
- 3. People with potential exposure to COVID-19 who are asymptomatic and have not tested positive for the virus should be accepted for admission consistent with your facility's pre-existing admission criteria and protocols.
 - a. Programs should request referring facilities to attest that the client has not had any new symptoms consistent with COVID-19 infections.
- 4. For the first 14 days after an individual arrives at the program, they should wear a mask when interacting with others, if masks are available and if possible, they should have their own room.
- 5. In the event that a referral is received directly from a hospital, CSU, BHCC admission, the 14-day isolation is not required, if the individual has tested negative for COVID-19 upon discharge.
 - a. A behavioral health residential facility can accept a resident diagnosed with COVID-19 under transmission-based precautions for COVID-19 as long as the facility can follow CDC guidance for transmission-based precautions. If a behavioral health residential facility cannot follow CDC guidance for transmission-based precautions, it must wait until these precaution requirements are discontinued.

Responding to an Individual Who Develops Symptoms

If an individual in a residential program develops symptoms indicative of a COVID-19 infection, the individual should be isolated in a single room or in the designated isolation room/area if a single room is not available. Exposed roommates should, if possible, also have their own rooms for 14 days and if they remain symptom-free, can then share a room with others. The individual, and others potentially exposed should wear a mask. Meals and medication should be taken in the room. Common bathrooms must be disinfected after each use.

Program Specific Guidance

Office of Adult Mental Health -Residential and Crisis Respite Apartments

AMH Intensive Residential

- o Providers must develop a COVID -19 plan based on the general guidance as outlined above and any additional guidance set forth by the CDC, GDPH and DBHDD.
- o These residential facilities must be staff 24 hours a day, 7 days a week, and all residents must be monitored and supported through this crisis.
- o New admissions should be accepted if the provider has the ability to follow CDC guidelines
- o Providers should continue accepting individuals from state hospitals, CSU, or BHCC. Admission is possible if the provider has more than one bed open. If the provider has only one bed available, they are not required to accept individuals and have the discretion to utilize this bed as an insolation bed if needed for residents presenting with symptoms of COVID 19.

AMH Semi – Independent Residential

o Providers must develop a COVID plan based on the general guidance as outlined above and any additional guidance set forth by the CDC, GDPH and DBHDD.

- o These residential facilities must be staffed the minimum of 36 hours and all residents must be monitored and supported through this crisis.
- o New admission should be accepted if the provider has the ability to follow the recommended guidelines by the CDC.

Independent Residential

- o Approval is granted for a telephone contact if the once per week face to face in person visit is not permissible.
- o If an enrolled individual is unreachable or refuses telephone contact for a period of 5 days, an in person, face-to- face contact is required.
- o If there is indication of behavioral health decline/decompensation, including but not limited to behavioral health symptom escalation, behavioral health crisis, or new behavioral health symptoms, there must be a face to face intervention within 24 hours for enrolled individuals.

Crisis Respite Apartments

- Approval is granted for telephone contacts if the required contacts per week face to face in person visit is not permissible.
- o If there is indication of behavioral health decline/decompensation, including but not limited to behavioral health symptom escalation, behavioral health crisis, or new behavioral health symptoms, there must be a face to face intervention within 24 hours for enrolled individuals.
- o Providers must respond to individuals in the case of a crisis call and provide the most appropriate service intervention needed for stabilization.

Office of Addictive Diseases – Residential and Women's Treatment Residential Intensive Residential

- o Providers must develop a COVID 19 plan based on the general guidance as outlined above and any additional guidance set forth by the CDC, DPH and DBHDD.
- o These residential facilities must be staff 24 hours and all residents must be monitored and supported through this crisis.
- o New admission should be accepted if the provider has the ability to follow CDC guidelines.

Semi – Independent Residential

- o Providers must develop a COVID 19 plan based on the general guidance as outlined above and any additional guidance set forth by the CDC, DPH and DBHDD.
- o A minimum of twelve (12) hours of clinical programming per week that includes but is not limited to therapy, education and relapse prevention.
- o Provision of individual therapy by telephone, group therapy and education in accordance with telehealth guidelines.
- o Self-help can be utilized via internet
- o In addition, services should be provided on-site vs in-clinic if possible, to reduce transportation of individuals.
- o Group modalities must not exceed 10 participants per group.
- o New admissions should be accepted if the provider has the ability to follow the recommended guidelines by the CDC.

Independent Residential

o Approval is granted for a telephone contact if the once per week face to face in person visit is not permissible.

- o Providers must respond to individuals in the case of a crisis call and provide the most appropriate service intervention needed for stabilization. Services provided by telehealth as outline by DBHDD guidance
- o Self-help groups via internet

Women's Treatment Service Residential Intensive Residential

- o Providers must develop a COVID plan based on the general guidance as outlined and any additional guidance set forth by the CDC, GDPH and DBHDD.
- o These residential facilities must be staff 24 hours a day, 7 days a week and all residents must be monitored and supported through this crisis.
- o New admissions should be accepted if the provider has the ability to follow CDC guidelines.
- o Mothers with child(ren) on the unit should identify emergency placement, if needed in the event of implementation of an isolation plan
- o Visitation of child(ren) within the child welfare system has been recommended to cease during this time, however, increase in communication via phone or video conferencing should be allowed.
- o Pregnant women should be supported in making changes in birth plan, if applicable, to comply with identified birthing hospital

Adolescent Intensive Residential

Intensive Residential

- o Providers must develop a COVID 19 plan based on the general guidance as outlined above and any additional guidance set forth by the CDC, GDPH and DBHDD.
- o These residential facilities must be staffed 24 hours a day, 7 days a week and all residents must be monitored and supported through this crisis.
- o New admission should be accepted if the provider has the ability to follow CDC guidelines.
- o Visitation guidelines above should be followed

Questions and Information

The Georgia Department of Public Health (DPH) and the Centers for Disease Control and Prevention (CDC) websites contain the most up-to-date information that will help us take sensible steps and support our ability to make health promoting choices. Guidance for clinicians and those providing direct service to individuals can be found at www.dph.georgia.gov. DBHDD will continue to provide updates via the Provider Newsletter: Network News. Should you have questions, please submit them to our Provider Relations team via the Provider Issue Management System or submit an email to DBHDD.Provider@dbhdd.ga.gov.

Please remember to be vigilant about hygiene practices.

Thank you for your continued partnership.

Cc: Monica Johnson, Director, Division of Behavioral Health Adrian Johnson, Assistant Director, Division of Behavioral Health



NOTICE: Georgia Crisis & Access Line

(#)

For access to services and immediate crisis help, call the <u>Georgia Crisis & Access Line (http://www.mygcal.com/)</u> (GCAL) at **1-800-715-4225**, available 24/7.

Coronavirus: COVID-19 Provider FAQs

Due to the recent developments with COVID-19 we have provided answers to the most asked provider questions. If you have a question that you do not see answered below please submit it via PIMS (https://dbhddapps.dbhdd.ga.gov/PIMS/Default.aspx).

What are the codes for Billing for telemedicine or telephonic billing?



Should we add the 95 Modifier for CPT codes in order to bill DCH for telemedicine?



Due to the allowance of the use telemedicine for certain services for precautionary measures, will there be any changes to the reimbursement rates for services? Or will Medicaid observe the Telehealth Site Visit code Q3014GT for Category of Service 44



How is Telemedicine different from Telehealth/Telephonic service delivery?



Will the DBHDD waive requirements of the Secretary of State related to the training requirements for LCSWs, LPCs, and LMFTs in order to provide these services (135-11)?



For new or renewed Individualized Recovery Plans, is it still a requirement for signatures?



Can an individual consent to telemedicine via telemedicine or phone?



Can an individual consent to telemedicine via email?



Isn't it true that all tele-medicine has to be done from a facility-based distant site?



Does the DBHDD guidance in the Provider Bulletins apply to the CMOs?



Do we use U6 or U7 modifiers when we bill for



The codes that will be billed must be identified as "telehealth services" by utilizing either a telehealth Place of Service (POS) code or a telehealth modifier (e.g., GT). In the DBHDD Guidance dated March 19, 2020 (https://files.constantcontact.com/c2257ded301/3e0220f3-4ccb-4a95-8451-ddo5f672b14c.pdf), for services in Table A, a provider would use the designated GT Modifier and bill the appropriate U Code for the particular practitioner level (no use of U6 or U7 as these codes are not currently programmed in the GAMMIS system). For the services in Table B, they would use the POS code.

Please remember that the only service codes that can be billed are those currently identified in the \underline{DBHDD} **Community Behavioral Health Provider Manual** (http://dbhdd.org/files/Provider-Manual-BH.pdf). If a provider tries to add any modifier to a base service code which is not identified in the manual, then it will deny.

Does the GT modifier get added to every claim now when we use telemedicine or telephonic/approved web platforms?



No. As specified in the DBHDD Guidance dated March 19,

(https://files.constantcontact.com/c2257ded301/3e0220f3-4ccb-4a95-8451-ddo5f672b14c.pdf), for services in Table A, a provider would use the designated GT Modifier and bill the appropriate U Code for the particular practitioner level. For the services in Table B, they would use the POS

The Georgia Board of Professional Counselors, Social Workers and I Family Therapists chose not to waive the "Telemental Health" traini for licensed practitioners, what does that mean for our behavioral h

The Georgia DBHDD is aware of the State of Georgia Rule and Regulation 135-11-.01 ing Professional Counselors, Social Workers, and Marriage and Family Therapists called "telemental health." The scope of applicability for that regulation is specific Counselors, Social Workers and Marriage and Family Therapists. No other practiti by DBHDD is required to take this training and therefore, those practitioners can p services as defined in the DBHDD March 19 correspondence. Additionally, if the pr by the Composite Board Rule and Regulation 135-11, they must complete the CEUs a before doing any telemedicine or telephonic service delivery. Once the regulatory e Board are fully met by one of those practitioners, then he/she may begin service del

Please see the notice posted by the DBHDD related to this here. (https://c:/Users/wtiegree/Downloads/Coronaviras%20SB%203.26.20 Policy%20 There is also a newly posted meeting announced (https://sos.ga.gov/index.php/lice Secretary of State website for April 3, 2020.

During the COVID-19 emergency, does **DBHDD** have a recommendation for getting a newly presenting person's ID and Medicaid ID scanned and uploaded at intake if we are doing BHA via telemedicine or telephone/allowed web platform (Zoom or via email)?

For initial intakes where an ID would typically be requested from an individual, the agency has the following alternatives, with the expectation that a physical copy will be made at the time of the next face to face meeting or, if that is not possible, that post-emergency period, this will be gathered for the health record:

- For a telemedicine intervention or other allowed visual platforms:
 - The person may show his/her ID to the practitioner. The person should show the ID long enough for the agency staff to document the ID#. That ID number should be documented in the record.
 - For Medicaid ID, a person's Medicaid eligibility and number can be verified in the GAMMIS portal; however, if the agency staff does not have access to that portal in real-time, the card can be visually shown, number recorded, and then the agency can verify after that intervention through the agency billing office.
 - Document that the ID was seen by the staff and note the identifying information in the medical record.
- For an audio mode of service delivery:
 - The person may tell the intake staff what type of ID he/she has (e.g. State of Georgia Driver's License) and then provide that license number to be documented in the medical record.
 - For Medicaid ID, a person's Medicaid eligibility and number can be verified in the GAMMIS portal; however, if the agency staff does not have access to that portal in real-time, the ID number can be read by the presenting person to the intake staff, the number recorded, and then the agency can verify eligibility and billing detail after that intervention through the agency billing office.
 - Document that the ID information was requested and document any identifying information in the medical record.

In terms of taking a photo of an ID via screenshot, DBHDD does not recommend this as phones/cameras and email have varying degrees of security, and therefore vulnerabilities for data breaches, security risk, identity theft, etc.

What happens if any crisis/safety issues arise during the telemedicine/telephonic assessment processes?



The Crisis Intervention service has been allowed to be provided via telephone for many years. Just as with a face-to-face crisis intervention, the practitioner should more to a quick situational

assessment; active listening and empathic responses to help relieve emotional distress; effective verbal and behavioral responses to warning signs of crisis related behavior; assistance to, and involvement/participation of the individual (to the extent he or she is capable) in active problem solving planning and interventions; facilitation of access to a myriad of crisis stabilization and other services deemed necessary to effectively manage the crisis; mobilization of natural support systems; and other crisis interventions as appropriate to the individual and issues to be addressed.

Document 448-73

If the individual has family or other natural supporters in the home, request and document verbal consent to engage those individuals in monitoring and supporting the person. As always, the Mobile Crisis network, Crisis Stabilization Units, Georgia Crisis and Access Line, and emergency responders are options when there is no other clinical alternative; however, we call upon the DBHDD Provider Network to use those resources prudently, using your best skill possible to stabilize the individual remotely to protect that individual from the need to be exposed to face-to-face service in a larger group setting.

When available either through the agency's EHR or through the individual, an individual's existing crisis plan should be utilized by the supporting practitioner when it is appropriate to the presenting situation. When a crisis plan does not exist, the practitioner will engage the individual/family/caregivers in a therapeutic plan that fosters a return to pre-crisis level of functioning and connect or reconnect the individual to treatment services and other community resources. Also, when available and offered by the individual, a Wellness Recovery Action Plan (WRAP) shall be utilized by the practitioner to support the individual's preferences. For individuals with a co-occurring IDD, an individual's behavior support plan shall be referenced during the crisis assessment and intervention process.

Also, depending on which code is used, note that the Crisis Intervention service can be provided between 2-3 hours in a day, so a practitioner can spend an extended time or make multiple calls to an individual in a single day to create an inhome stabilization plan. Family Training can also be quickly engaged by the same practitioner to work with those individuals on what to monitor. If there are no in-home family members, consider friends or neighbors who may be supporters to the individual, using Case Management for adults or Community Support for youth to engage those other released parties in a supporting crisis/safety plan.

Will I be able to come to work during the Governor's shelter in place forth to work?

At this time, we are unable to provide guidance related to the Shelter in Place order mation will be available on the Department of Public Health (DPH) website as this url=https%3A%2F%2Fdph.georgia.gov%2Fnovelcoronavirus&data=02%7C01%7CPa Walden%40dbhdd.ga.gov%7C78b52312816140doba5008d7d72f444f%7C512da10d0

Additionally, DBHDD is not able to provide documentation to provider agencies as view the Governor's order once it has been signed to ensure that your agency meets

Are any employee trainings waived as a result of the COVID-19 crisis?

Case 1:16-cv-03088-ELR



At this time, the only training that has been adjusted to date is for CPR and CPI. This was distributed in a Provider Relations special bulletin on 3/31/20. Any future allowances that are made will be communicated via the Provider Relations Special Bulletins.

We are trying to hire new staff and can't get fingerprinting done. May we waive the fingerprinting for this time?



Due to Covid-19, DBHDD understands that some finger-printing sites have reduced hours or are closed. Therefore, during Georgia's Public Health State of Emergency, the "attestation" process set forth in the DBHDD policy-COVID-19 2020: DBHDD Community Behavioral Health Services Policy Modifications – 3/26/2020 and can be found at the following link to PolicyStat: https://gadbhdd.policystat.com/policy/7845537/latest/ (https://gadbhdd.policystat.com/policy/7845537/latest/)

Will there be another service adjustment memo based on the Georgia Composite Board decision? How does this impact those that are not licensed? Many of the services identified on the service adjustment memo are provided by non-licensed paraprofessionals.



The State of Georgia Rule and Regulation 135-11-.01 and the rules governing Professional Counselors, Social Workers, and Marriage and Family Therapists on the use of a term called "telemental health" are only applicable to Professional Counselors, Social Workers, and Marriage and Family Therapists. No other practitioner type recognized by DBHDD is required to take this training and therefore, those other practitioners can proceed with delivering services as defined in the DBHDD March 19 correspondence.

For any of the licensed practitioner noted above that is governed by the Composite Board Rule and Regulation 135-11, they must complete the CEUs as defined by the Board before doing any telemedicine or telephonic service delivery. Once the regulatory expectations of the Board are fully met by one of those practitioners, then they may begin service delivery. Even though the Board did note vote to waive this requirement completely, they did vote to allow all continuing education courses to be completed online.

Can agencies code and bill unsuccessful attempts to reach individuals served?



There is no provision for "billing" for attempts at engaging individuals in an intervention. Only interventions directly with the individual (or collateral as indicated in a specific service definition) are billable. If an CST RN is not available (on leave/quarantined, etc.), can an outpatient RN (or other RN in the agency) provide services and bill CST? (Or do they bill outpatient?)

^

The agency should first consult its own CST Organizational Plan which requires the following to be met:

CLINICAL OPERATIONS, Item 13: The organization must have an CST Organizational Plan that addresses the following:

 Organizational Chart, staffing pattern, and a description of how staff are deployed to assure that the required staff-to-consumer ratios are maintained; including how unplanned staff absences, illnesses, and emergencies are accommodated;

If the agency relies on another agency nurse to fulfill the role of the CST nurse, then that nurse is acting as a CST staff and should bill under the CST code. He/she should also be participating as a team member to the best of the agency's ability during this COVID-19 crisis.

What is the status of RN/LPN services, specifically codes T1002 & T1003 which include education and training, related to special conditions?



DBHDD considers the title Nursing Assessment and Health Services as an umbrella naming convention for all of the Nursing Services included in the BH Provider Manual. Therefore, the Special Conditions are applicable to this group as a whole.



NETWORK BULLETIN



TWO IMPORTANT ANNOUNCEMENTS **AND** TRAINING OPPORTUNITIES

Background Check Variance

As stated in a previous special bulletin, due to Covid-19, DBHDD recognized that some fingerprinting sites had reduced hours or were closed. Therefore, during Georgia's Public Health State of Emergency, the "attestation" process set forth in the DBHDD policies below are in effect as stated therein.



Click here to access the required cover letter and attestation that must be submitted to the DBHDD Office of Enterprise Compliance, Criminal History Background Checks Section prior to employment. The cover letter and attestation are also available as attachments in the policies noted below.

COVID-19 2020: DBHDD Community Developmental Disability Services Policy Modifications - 3/26/2020

COVID-19 2020: DBHDD Community Behavioral Health Services Policy Modifications -3/26/2020



Georgia COVID-19 Emotional Support Line

The Georgia COVID-19 Emotional Support Line provides 24/7 free and confidential assistance to callers needing emotional support or resources information as a result of the COVID-19 pandemic. The Emotional Support Line is staffed by volunteers, including mental health professionals and others who have received training in crisis counseling.

Training Opportunities

2x2 Series: Daily Self-Care Tips and Support for Health Care and Emergency Response Workers

DBHDD invites you to participate in our **2x2 Series: Daily Self-Care Tips and Support for Health Care and Emergency Response Workers**. These Webex events are designed to provide daily self-care tips and support for health care and emergency response workers. Each session will provide attendees with mental health tips about managing stress, grief, work/life balance, and wellness.

NOTE: The sessions will utilize the WebEx webinar online conferencing system. WebEx allows participants to log on to a website from their computer and view the facilitator's information online, while listening to the facilitator through the use of a simultaneous telephone conference call.

All participants must use the links below to register for the 2x2 sessions. Additionally, please note that it is strongly encouraged that you join the webinar 10-15 minutes prior to the start time to ensure that you do not experience any connectivity issues. Although all attendees will be muted, the chat box will be functional, and all attendees are encouraged to ask questions and share thoughts through the interactive chat. The facilitator will allot time for Q&A at the end of the presentation.

Below is the date, time, session title, and registration link for the next four sessions (the password for each session is "2by2"):

April 7, 2020, 2:00 to 2:30 p.m.: 2X2: Family Wellness Attendee Registration

April 8, 2020, 2:00 to 2:30 p.m.: 2X2: Mindfulness Techniques to Manage Stress Attendee Registration

April 9, 2020, 2:00 to 2:30 p.m.: 2X2: Creating a Person Centered Self-Care Kit Attendee Registration

April 10, 2020: State Holiday; check out this **live 30-minute** meditation from the Smithsonian Institute at 12:15 p.m.

If you cannot attend the live sessions, each one will be recorded and available for review on the DBHDD website by **clicking here**.

Questions? Please email DBHDDLearning@dbhdd.ga.gov.

Teleheath Training and Consultation (TLC) Tuesdays

TELEHEALTH LEARNING & CONSULTATION (TLC)
TUESDAYS
9-10 a.m. MT / 10-11 a.m. CT ◀



The Southeast Mental Health Technology Transfer Center (MHTTC) agency, associated with the Substance Abuse and Mental Health Administration (SAMHSA), is offering an online series designed to support providers in utilizing telehealth services. Please join them for Telehealth Learning and Consultation (TLC) Tuesdays, an online series for providers who are new to or unfamiliar with telehealth.

These will occur from 11 am - 12 pm Eastern Standard Time Tuesday through April.

Case 1:16-cv-03088-ELR Document 448-73 Filed 11/29/23 Page 565 of 627

During each hour-long session, the Technology Transfer Center (TTC) Network specialists will spend 20 minutes addressing a specific topic, then answer questions submitted by TLC Tuesday registrants. Recordings of the 20-minute presentations, as well as additional resources, will be posted on the web page as they become available.

You must register separately for each TLC Tuesdays session below. While filling out the registration form, you will prompted to submit any questions you might have. Register by clicking one of the dates below. Certificates of completion will be available.

April 7: Telehealth Billing
April 14: Telehealth Tools
April 21: Telehealth with Children and Adolescents
April 28: Telehealth Troubleshooting

Office of Provider Relations

Director

Lynn Copeland

Senior Provider Relations Manager

Carole Crowley

Provider Relations Managers

Sharon Pyles Tim Strickland Lisa Sweat



For Provider Relations inquiries, please contact us at DBHDD.Provider@dbhdd.ga.gov

BE WELL







Georgia Department of Behavioral Health & Developmental Disabilities

Judy Fitzgerald, Commissioner

Division of Behavioral Health

To: All Regions and DBHDD-Contracted PATH Providers

From: Maxwell Ruppersburg, Director, Office of Supportive Housing, DBHDD

Date: April 7, 2020

Re: Guidance for PATH Teams during COVID-19 Health Crisis

In response to the statewide Shelter in Place order and Public Health State of Emergency in Georgia as a result of COVID-19, as well as the increasing pressures placed on the homeless and behavioral health system across the state, DBHDD and the Office of Supportive Housing is making programmatic accommodations and issuing guidance for PATH Team providers around the state.

During this time, it remains critical that PATH Teams continue to remain active so that vulnerable individuals in need continue to receive services and support. We will continue to adapt and respond to the rapidly changing environment in which we are operating around the state.

Currently in effect, all Supportive Housing Referrals, once approved, will receive a Notice to Proceed for GHVP and are not being asked to apply first for alternative resources. We will continue to do our best to make programmatic accommodations to support our providers and the individuals we serve.

PATH Teams should follow the below guidance:

- Continue serving individuals enrolled in PATH services, utilizing telephonic or virtual communication whenever possible and in-person whenever necessary, using appropriate safeguards.
- Maintaining outreach efforts while taking necessary efforts to limit risks of exposure.
- 3. Continue facilitating the NSH assessment and referral process.
- 4. Regular communication and coordination with local partner agencies and Continuums of Care.
- ☐ Ensure all client data and service interaction is accurate, current, and properly reflected in HMIS.
- 7. Help educate clients and colleagues about best practices for maintaining personal health and safety and for reducing the likelihood of exposure and spread of COVID-19.
- 8. Utilize the HUD COVID-19 Screening Tool and stay up to date on CDC guidance on COVID-19.
- Assist individuals who are currently enrolled in PATH or referred by PATH for housing with their Georgia Housing Voucher Program (GHVP) renewals as needed.
- 10. Coordinate with the DBHDD Regional Field Office for any referrals for individuals that are discharging from the state hospital who are homeless and in need of supportive housing.
- 11. Coordinate with the Housing Outreach Coordinator for referrals for individuals transitioning from a jail or prison.
- 12. Continue to maintain compliance with contract deliverables and communicate regularly with the Office of Supportive Housing regarding any identified needs or challenges. We are here to help □

This guidance remains in effect until further notice and we will provide further updates as soon as the situation changes.

The Centers for Disease Control and Prevention (CDC) has provided the following interim guidance for homeless services outreach workers based on what is currently known about coronavirus disease 2019 (COVID-19). The CDC is updating this interim guidance as additional information becomes available.

When COVID-19 is spreading in your community, assign outreach staff who are at <u>higher risk for severe</u> <u>illness</u> to other duties. Advise outreach staff who will be continuing outreach activities on how to protect themselves and their clients from COVID-19 in the course of their normal duties. Instruct staff to:

• Greet clients from a distance of 6 feet and explain that you are taking additional precautions to protect yourself and the client from COVID-19.

- Screen clients for symptoms consistent with COVID-19 by asking them if they have a fever, new or worsening cough, or shortness of breath.
 - o If the client has a cough, immediately provide them with a surgical mask to wear.
 - If urgent medical attention is necessary, use standard outreach protocols to facilitate access to healthcare.
- Continue conversations and provision of information while maintaining 6 feet of distance.
- Maintain good hand hygiene by washing your hands with soap and water for at least 20 seconds or using hand sanitizer (with at least 60% alcohol) on a regular basis.
- Wear gloves if you need to handle client belongings. Wash your hands or use hand sanitizer (>60% alcohol) before and after wearing gloves.
- If at any point you do not feel that you are able to protect yourself or your client from the spread of COVID-19, discontinue the interaction and notify your supervisor. Examples include if the client declines to wear a mask or if you are unable to maintain a distance of 6 feet.
- Provide all clients with hygiene products, when available.
- Street medicine and healthcare worker outreach staff should review and follow recommendations for healthcare workers.
- Review <u>stress and coping resources</u> for yourselves and your clients during this time.

The work of PATH Teams and the provider network remains critical and ever needed during this time of crisis for so many around the state. Please continue to exercise personal caution and recommended physical distancing and hygiene practices to safeguard the health of yourself and those around you.

DBHDD Commissioner Judy Fitzgerald has issued a <u>letter of exemption</u> explaining the Governor's Shelter in Place order does not apply to DBHDD provider staff. It is not necessary to use this letter under the law.

Please be sure to regularly check the <u>CDC</u> and <u>Georgia DPH</u> websites for the most up-to-date information about COVID-19 and remember to be vigilant about personal hygiene.

If you have additional questions that relate to COVID-19 please submit them to the provider relations email so that they are properly tracked. That email is DBHDD.GA.GOV

We appreciate everything you do □

CC:

Monica Johnson, Director, Division of Behavioral Health, DBHDD Adrian Johnson, Assistant Director, Division of Behavioral Health, DBHDD Letitia Robinson, Assistant Director, Office of Supportive Housing, DBHDD David Whisnant, Division Director, Housing Assistance Division, DCA Cynthia Patterson, Director, Office of Homeless and Special Needs Housings, DCA

DBHDD-Contracted Providers of PATH Services:

DBHDD Region	Provider Agency				
1	Hope Atlanta				
2	Serenity				
3	Community Friendship, Inc. (CFI)				
3 St. Joseph Mercy Care					
3	Hope Atlanta				
3	Grady Hospital				
3	Community Advance Practice Nurses (CAPN)				
4	4 Legacy Behavioral Health Services				
	Chatham Savannah Authority for the Homeless (CSAH)				
	New Horizons CSB				



VERSION 3

COVID-19 2020: DBHDD Community Behavioral Health Services Policy Modifications

EFFECTIVE 4/8/2020

Current Status: Old PolicyStat ID: 7895302

Creation: 3/26/2020 Effective: 4/8/2020 Last Reviewed: 4/8/2020 Georgia Department Last Revision: 4/8/2020 of Behavioral Health **Next Review:** 10/5/2020 & Developmental D·B·H·D·D Disabilities Owner:

Monica Johnson, MA, LPC:

Director, Division of Behavioral

Chapter: Admin Issues for BH & DD

Services

Sections:

COVID-19 2020: DBHDD Community Behavioral Health Services Policy Modifications - 4/8/2020

EFFECTIVE IMMEDIATELY

APPLICABILITY

DBHDD Providers of Community Behavioral Health Services

POLICY

In response to the continued transmission of COVID-19, where necessary new measures are in effect to minimize community spread of the virus, and to assist in the continued delivery of community behavioral health services.

Modifications as described in this policy refers to the restriction, enhancement, relaxation, and partial or full suspension of existing policies in PolicyStat, as applicable to the service. This policy includes full details of the alternate requirement(s) or procedures.

The following temporary modifications to the policies listed below are pertinent to community behavioral health services, effective immediately. Please refer to the full policy via the hyperlink, noting the alternate requirements applicable until further notice.

This policy will be updated as necessary. This policy remains in effect until the Governor of the State of Georgia lifts the Emergency Declaration.

- 1. **Temporary suspension** of the site visit requirement for behavioral health provider enrollment, per Recruitment and Application to become a Provider of Behavioral Health Services, 01-111 are permitted as follows:
 - a. New Applicants
 - i. Site visits are currently suspended for new providers. Applications for new providers will remain in a pending status until site visits resume.
 - b. Existing Providers
 - i. Site visits for new sites are suspended. Site visits will be waived for existing

DBHDD approved providers applying for services at an existing approved site or a site that is currently licensed by Healthcare Facility Regulation (HFR). Pending applications that require a site visit and do not meet these criteria will remain in pending status until site visits resume.

c. Applicant Forum

- i. Applicants must have attended one of the two most recent BH Provider Enrollment Forums (held August 14, 2019 and December 11, 2019) to be eligible to submit a Letter of Intent (LOI) during this enrollment cycle. LOIs must be submitted to the Georgia Collaborative via email at GA Enrollment@Beaconhealthoptions.com. LOIs submitted before May 1 or after May 31 will not be accepted or processed. LOIs submitted via USPS mail may experience delays in processing. It is highly recommended to submit LOIs via email.
- 2. A *partial suspension* of the fingerprinting requirement described in Criminal History Record Check for DBHDD Network Provider Applicants, 04-104 as follows:
 - a. DBHDD's Provider Network must have each person subject to Policy 04-104 complete the "Network Provider Applicant Attestation," Attachment A to this policy, instead of completing the fingerprint based background check stipulated in Policy 04-104.
 - b. Within thirty (30) days of cessation of the Public Health Emergency, all persons who signed the Network Provider Applicant Attestation instead of completing the fingerprint based background check must complete a fingerprint based background check as required by Policy 04-104. The provider is responsible for sending any person who signed the Network Provider Applicant Attestation for a fingerprint based background check.
 - c. The provider is also responsible for sending to DBHDD's Criminal History Background Check (CHBC) section each signed Network Provider Applicant Attestation, while retaining a copy in the applicant's personnel file. The provider must send the signed and dated Attestation to CHBC, and acknowledge receipt of an email from CHBC confirming acceptance of the Attestation, before the applicant begins working. The Individual Assessment process set forth in section D of Policy 04-104 does not apply to persons who sign the Network Provider Applicant Attestation.
 - d. The Attestation cannot be used by Network Provider Applicants who were fingerprinted for a fingerprint- based background check within 30 days prior to the declaration of the Public Health Emergency.
- 3. A *partial suspension* of the fingerprinting requirement described in <u>Criminal History</u> Record Check for Individual Provider Applicants, 04-111 is permitted as follows:
 - a. All applicants who are subject to Policy 04-111 must complete the "Individual Provider Attestation," Attachment B to this policy, instead of completing the fingerprint based background check documented in Policy 04-111.
 - b. Within thirty (30) days of cessation of the Public Health Emergency, all applicants who signed the Individual Provider Attestation instead of completing the fingerprint based background check must complete a fingerprint based background check as required by Policy 04-111.
 - c. DBHDD Provider Enrollment is responsible for sending to DBHDD's Criminal History

Background Check (CHBC) section all signed Individual Provider Attestations and for acknowledging receipt of an email from CHBC confirming acceptance of the Attestation, before the Individual Provider Applicant can be considered eligible. The Individual Assessment process set forth in Part D of Policy 04-111 does not apply to applicants who sign the Individual Provider Attestation.

- d. The Attestation cannot be used by Individual Provider Applicants who were fingerprinted for a fingerprint based background check within 30 days prior to the declaration of the Public Health Emergency.
- 4. A *partial suspension* of the income verification requirements using tax returns, pay check stubs, verification of benefits from other federal or state agencies as stipulated in Sections B.3 and F.2 of Payment by Individuals for Community Behavioral Health Services, 01-107 has been made as follows:
 - a. For the period of the Public Health Emergency related to COVID-19, DBHDD waives the requirement for income verification to access state funded behavioral health services.
 - b. Provider agencies are required to request attestation of income from individuals served and verify authenticity to the best of their ability.
 - i. If verification is unavailable due to resource constraints related to COVID-19, providers are required to note this in the record. At the end of the public health emergency, providers will be required to verify individuals income status within 90 days.

DBHDD sincerely appreciates your compliance with these measures throughout this Public Health Emergency.

Attachments

A - COVID-19 2020 - Attestation of Absence of Barrier Crimes Data & Cover Letter.docx

B - COVID-19 2020 - Attestation of Absence of Barrier Crimes Data & Cover Letter.docx

Approval Signatures

Approver	Date
Anne Akili, Psy.D.: Director, Policy Management	4/8/2020
Monica Johnson, MA, LPC: Director, Division of Behavioral Health	4/8/2020
Anne Akili, Psy.D.: Director, Policy Management	4/7/2020



Judy Fitzgerald, Commissioner

Office of Enterprise Compliance

Two Peachtree Street, NW • 1st Floor • Atlanta, Georgia 30303-3142 • Telephone: 404-463-2507 • Fax: 770-359-5473

[,					
, <u> </u>	Last Name	First Nam	e	Middl	le Initial
	Social Security No.	Height	Weight	Eye color	Hair Color
	Date of Birth	Sex		Race	
	Street Address		City	State	Zip

attest that I have not been convicted of nor have pending charges for any crime listed on Barrier Record Data (Attachment D of <u>Criminal History Record Check for DBHDD</u> <u>Network Provider Applicants</u>, 04-104, a copy of which has been provided to me).

I also attest that:

- 1. I am not currently on probation as a First Offender for a crime listed on Barrier Record Data (Attachment D);
- 2. I am not awaiting final disposition on charges for any crime referenced on the Barrier Record Data (Attachment D);
- 3. I do not knowingly have an outstanding warrant for any crime referenced on the Barrier Record Data (Attachment D);
- 4. I do not have a finding of guilty but mentally ill (GBMI) for any crime referenced on the Barrier Record Data (Attachment D);
- 5. I do not have a finding of guilty with intellectual disability (GWID) for any crime referenced on the Barrier Record Data (Attachment D); and
- 6. I do not have a finding of not guilty by reason of insanity (NGRI) for any crime referenced on the Barrier Record Data (Attachment D).
- 7. I do not have any convictions within the last 12 months.

This form serves as a contingency for employment. Within 30 days of the termination of the Public Health State of Emergency, I understand that I will be required to complete a fingerprint based background check and if any information stated hereon is found to be falsified or untrue, I could be deemed ineligible for continued employment by a DBHDD network provider. I also understand that prior to being fingerprinted, if any information stated hereon is discovered to have been falsified or is found to be untrue, I could be deemed ineligible for continued employment.

Signature		
Date		



Judy Fitzgerald, Commissioner

Office of Enterprise Compliance

Two Peachtree Street, NW • 1st Floor • Atlanta, Georgia 30303-3142 • Telephone: 404-463-2507 • Fax: 770-359-5473

TO: DBHDD Provider Network

FROM: DBHDD Office of Enterprise Compliance

Criminal History Background Checks Section

RE: Policy No. 04-104 Attestation

Immediately after a person subject to Policy No. 04-104, as modified during the Public Health State of Emergency, completes the Attestation required under the modified policy, send the Attestation to CHBC by facsimile to (770) 359-1622, or via email at DBHDD-CRS@DBHDD.GA.GOV. with this Cover Sheet after completing the information required below:

Provider Name	_		
Name of Direct Contact	_		
Contact Phone Number	_		
Email address	_		

If you have questions, please contact our office at 404-463-2507 or 404-232-1641.



Judy Fitzgerald, Commissioner

Office of Enterprise Compliance

Two Peachtree Street, NW • 1st Floor • Atlanta, Georgia 30303-3142 • Telephone: 404-463-2507 • Fax: 770-359-5473

·H·D·D				
I,				
Last Name	First Nam	e	Middl	le Initial
Social Security No.	Height	Weight	Eye color	Hair Color
Date of Birth	Sex		Race	
Street Address		City	State	Zip
attest that I have not been cor Barrier Record Data (Attachn provided to me). I also attest that:				
1. I am not currently on Record Data (Attachmo	-	First Offende	r for a crime lis	sted on Barrier
2. I am not awaiting fina Barrier Record Data (A		_	any crime refe	erenced on the
3. I do not knowingly hav Barrier Record Data (A		_	r any crime ref	erenced on the
4. I do not have a finding on the Barrier Record		•	BMI) for any cri	ime referenced
5. I do not have a finding) for any crime

- 6. I do not have a finding of not guilty by reason of insanity (NGRI) for any crime referenced on the Barrier Record Data (Attachment D).
- 7. I do not have any convictions within the last 12 months.

This form serves as a contingency for employment. Within 30 days of the termination of the Public Health State of Emergency, I understand that I will be required to complete a fingerprint based background check and if any information stated hereon is found to be falsified or untrue, I could be deemed ineligible to be an individual provider. I also understand that prior to that time if it is discovered that information stated hereon is falsified or found to be untrue, I could be deemed ineligible to be an individual provider.

Signature		
Date		

2 Peachtree Street, NW • Atlanta, Georgia 30303 • 404.657.2252 dbhdd.georgia.gov • Facebook: Georgia DBHDD • Twitter: @DBHDD



Judy Fitzgerald, Commissioner

Office of Enterprise Compliance

Two Peachtree Street, NW • 1st Floor • Atlanta, Georgia 30303-3142 • Telephone: 404-463-2507 • Fax: 770-359-5473

TO: DBHDD Provider Network

FROM: DBHDD Office of Enterprise Compliance

Criminal History Background Checks Section

RE: Policy No. 04-104 Attestation

Immediately after a person subject to Policy No. 04-104, as modified during the Public Health State of Emergency, completes the Attestation required under the modified policy, send the Attestation to CHBC by facsimile to (770) 359-1622, or via email at DBHDD-CRS@DBHDD.GA.GOV. with this Cover Sheet after completing the information required below:

Provider Name	_			
Name of Direct Contact	_			
Contact Phone Number	_			
Email address				

If have questions, please contact our office at 404-463-2507 or 404-232-1641.



Judy Fitzgerald, Commissioner

D·B·H·D·D

Division of Behavioral Health

To: All GHVP Providers

From: Maxwell Ruppersburg, Director, Office of Supportive Housing, DBHDD

Date: 4/09/2020

Re: Emergency Changes to Bridge Funding Policies during COVID-19

In response to the Public Health State of Emergency in Georgia as a result of COVID-19, as well as the increasing pressures placed on the homeless and behavioral health system across the state, DBHDD and the Office of Supportive Housing is making programmatic accommodations for Bridge Funding.

It is our intention to provide additional flexibility to ensure the continued stability and wellbeing of the individuals being served by GHVP. To that end, we are authorizing the use of Bridge Funding to cover short-term emergency/transitional housing in the form of hotel/motel stays, as well as for the payment of monthly utility and food expenses for individuals experiencing a financial impact during COVID-19.

□se of Bridge Funding for Hotel/Motel Stays during Housing Search:

- 1. Providers may utilize Bridge Funding to provide individuals with a Notice to Proceed for GHVP with emergency temporary housing through the purchase of a hotel/motel stay.
- 2. Providers should first pursue the use of Emergency Shelter Grantee hotel/motel vouchers when available in the community.
- 3. The maximum allowance for Bridge Funding for hotel/motel stays is □1,□00 per household.
- 4. Providers can submit Bridge Funding claims for hotel/motel stays per normal procedures under the "Other" (T1999-HE-□1) billing code. All receipts should be properly documented.
- Providers should seek to collaborate within the Region to identify the best possible pricing.

□se of Bridge Funding for Emergency Coverage of **□**tility Expenses:

- 1. Providers may provide emergency coverage of utility expenses for individuals who are currently housed via GHVP and experiencing a harmful financial impact as a result of the COVID-19 crisis.
- 2. Providers serving individuals without income should seek the assistance of a DBHDD Medical Eligibility Specialist (MES) and SSI/SSDI Outreach, Access, and Recovery (SOAR) Specialist. Contact information for MES/SOAR specialists for all regions is at the bottom of this document.
- 3. Individuals without employment should receive assistance in applying for unemployment benefits.
- 4. Providers can submit Bridge Funding claims for utility bill expenses per normal procedures under the "Utility Deposits" (T1999-HE-D1) billing code. All receipts should be properly documented.

□se of Bridge Funding for Emergency Coverage of Food/□rocery Expenses:

- 1. Providers may provide emergency coverage of grocery expenses for individuals who are currently housed via GHVP and experiencing a harmful financial impact as a result of the COVID-19 crisis.
- 2. Providers should seek support from local food banks and assist eligible individuals in applying for SNAP food benefits prior to utilization of Bridge Funding to cover ongoing grocery expenses.
- 3. Food expenses should follow the maximum monthly allowance schedule below, based on household size. These amounts are based on federal SNAP standards:

	□ household members: □921
2 household members: □3□□	7 household members: □1,018
3 household members: □□09	8 household members: □1,1□4
4 household members: □□4□	Each additional person: □14□
□ household members: □7□8	·

4. Please assist clients with maximizing the use of their budget to meet their long-term needs.

□ Providers can submit Bridge Funding claims for ongoing food expenses per normal procedures under the "Food/Grocery" (T1999-HE-FG). All receipts should be properly documented.

For uestions about bridge claims, please contact: GACollaborativePR@beaconhealthoptions.com.

These supports are being extended temporarily as a stop gap measure to ensure the individuals we serve do not experience unnecessary hardship during this crisis. All impacted individuals need to be connected with existing state and federal benefit programs to ensure they can continue to receive available and necessary supports so that their stability can persist after the resolution of this public health crisis.

The policy change providing for Emergency Rental Coverage remains in effect. Providers should ensure individuals are assisted with filing for unemployment benefits if they have lost their employment.

These temporary policy changes remain in effect until further notice and are subject to change.

The work of the provider network remains critical and ever needed during this time of crisis for so many around the state. Please continue to exercise personal caution and recommended physical distancing and hygiene practices to safeguard the health of yourself and those around you.

DBHDD Commissioner Judy Fitzgerald has issued a <u>letter of exemption</u> explaining the Governor's Shelter in Place order does not apply to DBHDD provider staff. It is not necessary to use this letter under the law.

Please be sure to regularly check the <u>CDC</u> and <u>Georgia DPH</u> websites for the most up-to-date information about COVID-19 and remember to be vigilant about personal hygiene.

- Unemployment applications can be submitted online here: https://dol.georgia.gov/ or call the local career center to apply by phone.
 - o Find the career center locator online here: https://dol.georgia.gov/locations/career-center
- Eligibility for food stamps/SNAP has been expanded during this emergency.
 - o Apply for food stamps/Medicaid online here: https://gateway.ga.gov/access/
 - To find food pantries in your area, text FINDFOOD (one word, no space) or COMIDA to 888-97□-2232.

If you have additional questions that relate to COVID-19 please submit them to the provider relations email so that they are properly tracked. That email is <u>DBHDD.Provider@DBHDD.GA.GOV</u>.

We appreciate everything you do □

CC:

Monica Johnson, Director, Division of Behavioral Health, DBHDD Adrian Johnson, Assistant Director, Division of Behavioral Health, DBHDD Letitia Robinson, Assistant Director, Office of Supportive Housing, DBHDD Hetal Patel, Regional Service Administrator, Region 1, DBHDD Dawn Peel, Regional Service Administrator, Region 2, DBHDD Gwen Craddieth, Regional Service Administrator, Region 3, DBHDD Jennifer Dunn, Regional Service Administrator, Region 4, DBHDD Jos□Lopez, Regional Service Administrator, Region □, DBHDD Ann Riley, Regional Service Administrator, Region □, DBHDD

MES/SOAR Specialist contact information on next page

MES/SOAR Specialists by DBHDD Region

Region	Name	Office	Mobile	Email
1	Martinita Smiley-Smith	770-781-⊡938	404-□23-□3□2	Martinita.smiley-smith@dbhdd.ga.gov
2	LaTarnesha Martin	70 □-792-728 □	70 - 49 - 0 - 0 - 0	Latarnesha.martin@dbhdd.ga.gov
2	Michi Smith	478-44 □-30 □0	404-430-9424	Michi.smith@dbhdd.ga.gov
3	Peter Ward	404-232-1 □27	404-272-47□8	Peter.ward@dbhdd.ga.gov
3	Shekira Davis	404-□□7-□410	404-□48-1009	Shekira.davis@dbhdd.ga.gov
3	Ivori Cullins-Baker	404-232-1 □□4	470-3□2-9179	Ivori.cullins-baker@dbhdd.ga.gov
4	Corey Stubbs	229-22 - 3984	229-379-4934	Corey.stubbs@dbhdd.ga.gov
	Michele Joseph	912-303-43 🗆 3	912-□□□-081□	Michele.Joseph@dbhdd.ga.gov
	Tandra Dickerson	70 ⊡- □□8-2304	70 □-32 □- □42 □	Tandra.dickerson@dbhdd.ga.gov

Darren Willis
Georgia SOAR State Lead
Budget Compliance/Medicaid MGR
404-□□7-1□□7 Office
404-804-4121 Mobile
Darren.willis@dbhdd.ga.gov

Regional Service Administrators and Regional Housing Transition Coordinators

Region	Position	First Name	Last Name	Email
1	Regional Services Administrator	Hetal	Patel	Hetal.Patel@dbhdd.ga.gov
1	Housing Transition Coordinator	Scarlett	Freelin	scarlett.freelin@dbhdd.ga.gov
2	Regional Services Administrator	Dawn	Peel	Dawn.Peel@dbhdd.ga.gov
2	Housing Transition Coordinator	April	Edwards	april.edwards@dbhdd.ga.gov
3	Regional Services Administrator	Gwen	Craddieth	Gwen.Craddieth@dbhdd.ga.gov
3	Housing Transition Coordinator	Jamie	□imbrough	jamie.kimbrough@dbhdd.ga.gov
4	Regional Services Administrator	Jennifer	Dunn	Jennifer.Dunn@dbhdd.ga.gov
4	Housing Transition Coordinator	Rachael	Holloway	rachael.holloman@dbhdd.ga.gov
	Regional Services Administrator	Jose	Lopez	Jose.Lopez@dbhdd.ga.gov
	Housing Transition Coordinator	Jeannette	Bacon	Jeannette.Bacon@dbhdd.ga.gov
	Regional Services Administrator	Ann	Riley	Ann.riley@dbhdd.ga.gov
	Housing Transition Coordinator	Sam	Page	Sam.Page@dbhdd.ga.gov



VERSION 4

COVID-19 2020: DBHDD Community Behavioral Health Services Policy Modifications

EFFECTIVE 4/23/2020

Current Status: Old PolicyStat ID: 7969896 Creation: 3/26/2020 Effective: 4/23/2020 Last Reviewed: 4/23/2020 Georgia Department Last Revision: 4/23/2020 of Behavioral Health **Next Review:** 10/20/2020 & Developmental D·B·H·D·D Disabilities Owner: Monica Johnson, MA, LPC: Director, Division of Behavioral Chapter: Admin Issues for BH & DD Services

Sections:

COVID-19 2020: DBHDD Community Behavioral Health Services Policy Modifications - 4/23/2020

EFFECTIVE IMMEDIATELY

APPLICABILITY

DBHDD Providers of Community Behavioral Health Services

POLICY

In response to the continued transmission of COVID-19, where necessary new measures are in effect to minimize community spread of the virus, and to assist in the continued delivery of community behavioral health services.

Modifications as described in this policy refers to the restriction, enhancement, relaxation, and partial or full suspension of existing policies in PolicyStat, as applicable to the service. This policy includes full details of the alternate requirement(s) or procedures.

The following temporary modifications to the policies listed below are pertinent to community behavioral health services, effective immediately. Please refer to the full policy via the hyperlink, noting the alternate requirements applicable until further notice.

This policy will be updated as necessary. This policy remains in effect until the Governor of the State of Georgia lifts the Emergency Declaration.

- 1. **Temporary suspension** of the site visit requirement for behavioral health provider enrollment, per <u>Recruitment and Application to become a Provider of Behavioral Health Services</u>, 01-111 are permitted as follows:
 - a. New Applicants
 - i. Site visits are currently suspended for new providers. Applications for new providers will remain in a pending status until site visits resume.
 - b. Existing Providers
 - i. Site visits for new sites are suspended. Site visits will be waived for existing

DBHDD approved providers applying for services at an existing approved site or a site that is currently licensed by Healthcare Facility Regulation (HFR). Pending applications that require a site visit and do not meet these criteria will remain in pending status until site visits resume.

c. Applicant Forum

- i. Applicants must have attended one of the two most recent BH Provider Enrollment Forums (held August 14, 2019 and December 11, 2019) to be eligible to submit a Letter of Intent (LOI) during this enrollment cycle. LOIs must be submitted to the Georgia Collaborative via email at GA Enrollment@Beaconhealthoptions.com. LOIs submitted before May 1 or after May 31 will not be accepted or processed. LOIs submitted via USPS mail may experience delays in processing. It is highly recommended to submit LOIs via email.
- 2. A *partial suspension* of the fingerprinting requirement described in Criminal History Record Check for DBHDD Network Provider Applicants, 04-104 as follows:
 - a. DBHDD's Provider Network must have each person subject to Policy 04-104 complete the "Network Provider Applicant Attestation," Attachment A to this policy, instead of completing the fingerprint based background check stipulated in Policy 04-104.
 - b. Within sixty (60) days of cessation of the Public Health Emergency, all persons who signed the Network Provider Applicant Attestation instead of completing the fingerprint based background check must complete a fingerprint based background check as required by Policy 04-104. The provider is responsible for sending any person who signed the Network Provider Applicant Attestation for a fingerprint based background check.
 - c. The provider is also responsible for sending to DBHDD's Criminal History Background Check (CHBC) section each signed Network Provider Applicant Attestation, while retaining a copy in the applicant's personnel file. The provider must send the signed and dated Attestation to CHBC, and acknowledge receipt of an email from CHBC confirming acceptance of the Attestation, before the applicant begins working. The Individual Assessment process set forth in section D of Policy 04-104 does not apply to persons who sign the Network Provider Applicant Attestation.
 - d. The Attestation cannot be used by Network Provider Applicants who were fingerprinted for a fingerprint- based background check within sixty (60) days prior to the declaration of the Public Health Emergency.
- 3. A *partial suspension* of the income verification requirements using tax returns, pay check stubs, verification of benefits from other federal or state agencies as stipulated in Sections B.3 and F.2 of Payment by Individuals for Community Behavioral Health Services, 01-107 has been made as follows:
 - a. For the period of the Public Health Emergency related to COVID-19, DBHDD waives the requirement for income verification to access state funded behavioral health services.
 - b. Provider agencies are required to request attestation of income from individuals served and verify authenticity to the best of their ability.
 - i. If verification is unavailable due to resource constraints related to COVID-19.

providers are required to note this in the record. At the end of the public health emergency, providers will be required to verify individuals income status within 90 days.

DBHDD sincerely appreciates your compliance with these measures throughout this Public Health Emergency.

Attachments

A - COVID-19 2020 - Attestation of Absence of Barrier Crimes Data & Cover Letter 4/23/2020.docx

Approval Signatures

Approver	Date
Anne Akili, Psy.D.: Director, Policy Management	4/23/2020
Monica Johnson, MA, LPC: Director, Division of Behavioral Health	4/23/2020
Anne Akili, Psy.D.: Director, Policy Management	4/23/2020



Georgia Department of Behavioral Health & Developmental Disabilities

Judy Fitzgerald, Commissioner

Office of Enterprise Compliance

Two Peachtree Street, NW • 1st Floor • Atlanta, Georgia 30303-3142 • Telephone: 404-463-2507 • Fax: 770-359-5473

I,					
,	Last Name	First Nam	e	Middl	e Initial
	Social Security No.	Height	Weight	Eye color	Hair Color
	Date of Birth	Sex		Race	
	Street Address		City	State	Zip

attest that I have not been convicted of nor have pending charges for any crime listed on Barrier Record Data (Attachment D of <u>Criminal History Record Check for DBHDD</u> <u>Network Provider Applicants</u>, 04-104, a copy of which has been provided to me).

I also attest that:

- 1. I am not currently on probation as a First Offender for a crime listed on Barrier Record Data (Attachment D);
- 2. I am not awaiting final disposition on charges for any crime referenced on the Barrier Record Data (Attachment D);
- 3. I do not knowingly have an outstanding warrant for any crime referenced on the Barrier Record Data (Attachment D);
- 4. I do not have a finding of guilty but mentally ill (GBMI) for any crime referenced on the Barrier Record Data (Attachment D);
- 5. I do not have a finding of guilty with intellectual disability (GWID) for any crime referenced on the Barrier Record Data (Attachment D); and
- 6. I do not have a finding of not guilty by reason of insanity (NGRI) for any crime referenced on the Barrier Record Data (Attachment D).
- 7. I do not have any convictions within the last 12 months.

This form serves as a contingency for employment. Within sixty (60) days of the termination of the Public Health State of Emergency, I understand that I will be required to complete a fingerprint based background check and if any information stated hereon is found to be falsified or untrue, I could be deemed ineligible for continued employment by a DBHDD network provider. I also understand that prior to being fingerprinted, if any information stated hereon is discovered to have been falsified or is found to be untrue, I could be deemed ineligible for continued employment.

Signature		
Date		



Georgia Department of Behavioral Health & Developmental Disabilities

Judy Fitzgerald, Commissioner

Office of Enterprise Compliance

Two Peachtree Street, NW • 1st Floor • Atlanta, Georgia 30303-3142 • Telephone: 404-463-2507 • Fax: 770-359-5473

TO: DBHDD Provider Network

FROM: DBHDD Office of Enterprise Compliance

Criminal History Background Checks Section

RE: Policy No. 04-104 Attestation

Immediately after a person subject to Policy No. 04-104, as modified during the Public Health State of Emergency, completes the Attestation required under the modified policy, send the Attestation to CHBC by facsimile to (770) 359-1622, or via email at **DBHDD-CRS@DBHDD.GA.GOV.** with this Cover Sheet after completing the information required below:

Provider Name		
Name of Direct Contact		
Contact Phone Number		
Email address		

If you have questions, please contact our office at 404-463-2507 or 404-232-1641.



NETWORK BULLETIN



UPDATE

IMPORTANT ANNOUNCEMENTS

Behavioral Health Telemedicine and Telephonic Guidance

The March 19, 2020 DBHDD Telemedicine and Telephonic Guidance indicates that DBHDD, in partnership with DCH, is allowing the service provision allowances in that guidance through April 30, 2020.

DBHDD is officially extending the allowances in this Guidance (and any other that references an April 30, 2020 end date) through the end of the public health emergency period, whenever it is declared.

IDD CONNECTS **Scheduled Downtime**

Please note, IDD Connects will be down this Monday, 4/27/20, from 6:00 pm to 12:00 am, in order to configure the system for the required Appendix K changes that are now in effect.



APPENDIX K Webinar Presentations and Operational Guidance

Below are the PowerPoint presentations from the IDD webinars regarding the Appendix K and the Operational Guidance. These presentations are also available on the DBHDD website by selecting the "COVID-19 Guidance, Memos, FAQs & More" from the homepage.

> **IDD PROVIDER WEBINAR -**4/15/20

SUPPORT COORDINATION WEBINAR -4/16/20

BILLING PRESENTATION WEBINAR -4/23/20

BACKGROUND CHECK VARIANCE

As stated in previous special bulletin, due to Covid-19, DBHDD recognized that some fingerprinting sites had reduced hours or were closed. Therefore, during Georgia's Public Health State of Emergency, the "attestation" process set forth in the DBHDD policies below are in effect as stated therein.



Please note that the time allowed to complete the required fingerprint based background check, once the Public Health State of Emergency is terminated, has been changed from 30 to 60 days for consistency in policy.

Click the links to access to the required cover letter and attestation that must be submitted to the DBHDD Office of Enterprise Compliance, Criminal History Background Checks Section prior to employment, for **Individual Providers** or for **Provider Agencies**. These documents are also available in the policies noted below.

COVID-19 2020: DBHDD Community Developmental Disability Services Policy Modifications - 4/23/2020

COVID-19 2020: DBHDD Community Behavioral Health Services Policy Modifications - 4/23/2020

Office of Provider Relations

Director

Lynn Copeland

Senior Provider Relations Manager

Carole Crowley

Provider Relations Managers

Sharon Pyles Tim Strickland Lisa Sweat



For Provider Relations inquiries, please contact us at DBHDD.Provider@dbhdd.ga.gov

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Georgia Department of Behavioral Health & Developmental Disabilities

Judy Fitzgerald, Commissioner

D·B·H·D·D

Division of Behavioral Health

TO: Georgia Medicaid-Enrolled Opioid Treatment Programs

FROM: Office of Addictive Diseases

Office of Medicaid Coordination

DATE: April 24, 2020

SUBJECT: Medication Assisted Treatment Guidance for the COVID-19 Emergency Response

Background: The Department of Behavioral Health and Developmental Disabilities (DBHDD) Office of Addictive Diseases (OAD) is Georgia's State Opioid Treatment Authority (SOTA). As such, DBHDD's OAD collaborates with other agencies in developing guidelines for establishing and/or closing Medication Assisted Treatment (MAT) Programs operating in Georgia. As the SOTA, DBHDD is also responsible for establishing guidelines for the administration of MAT programs. In this capacity we are concerned with the continuity of care for all individuals currently enrolled in Opioid Treatment Programs in Georgia. Due to the current challenge of addressing COVID-19 in our state, we are providing additional guidance regarding take-home medication, telehealth, and billing for medication administration.

Updated Guidance:

For Opioid Treatment Providers, DBHDD is offering the following additional clarification for its network of providers as a follow-up to the March 17, 2020 and April 1, 2020 guidance:

- DBHDD does not reimburse for claims for pharmacy and medication nor its preparation or dispensing;
- DBHDD is permitting telemedicine/telephonic supervision (video-enabled only) of the individual's self-administration of take-home medication to be billed as either Medication Administration or Opioid Maintenance in accordance with those definitions in accordance with the April 1, 2020 guidance. While we realize that many individuals do not have a video-enabled phone or a computer to use the video-enabled approved web platforms, this is a best-case allowance for the OTP nurse or pharmacist to be able to bill for this service while adhering to physical distancing as possible;
- DBHDD is permitting Nursing Assessment to occur via telemedicine, telephonic (with or without video-enabling capability), and/or web-based approved platforms for interaction. During the COVID-19 emergency response period, this may be in-person or via telemedicine/other telehealth platforms, as is clinically feasible and appropriate) with the individual to monitor, evaluate, assess, and/or carry out a physician's orders regarding the physical and/or psychological problems of the Individual; and
- In March 19, 2020 Guidance, DBHDD outlined that vitals (i.e. in person services) would be required for 50% of services billed as Nursing Assessment and Care. Due to the high frequency of contact with individuals served in these specific programs, DBHDD is **not** requiring the OTP programs to comply with this provision. For OTP programs, Nursing Assessment and Health can be provided via telehealth, without regard to a ratio of inperson visits.

• DBHDD SOTA Guidance for Infection Control and Prevention of COVI-19, which was sent on **March 17, 2020**, remains in effect. In addition, we are asking all provider to report cases of COVID-19 to Georgia Department of Public Health. https://dph.georgia.gov/epidemiology/disease-reporting

Finally, again, except for rare scenarios, the DBHDD does not pay for medication (take-home or otherwise).

Please join us to discuss this guidance via WebEx on Thursday, April 30, 2020 from @ 10 a. m. https://globalpage-

prod.webex.com/join?surl=https%3A%2F%2Fsignin.webex.com%2Fcollabs%2F%23%2Fmeetings%2Fjoinbynumber%3FTrackID%3D%26hbxref%3D%26goid%3Dattend-meeting&language=en_US Meeting number (access code): 719 782 971

DBHDD's response to the State of Public Emergency for COVID-19 is continuously adapting based upon the needs of the community, the provider network, and most importantly, the people we mutually serve. Please know that as DBHDD receives more information about the needs of our state we will respond accordingly and keep you, our partners, well informed. For questions and further discussion please call 404-416-5225 or email <a href="https://www.new.gov.network.n



NETWORK BULLETIN



ATTENTION I/DD PROVIDERS

DBHDD COMMUNITY SETTINGS Reopening Recommendations

During the temporary COVID-19 Public Health Emergency, I/DD community-based services that are typically provided in group settings have been adversely impacted. The DBHDD provider network has ensured ongoing connection with individuals using various strategies and telehealth options to maintain necessary services.

On May 14, 2020, many provisions of the Georgia statewide shelter in place order will expire. However, Governor Brian Kemp extended the order that Georgia's citizens who are most vulnerable to COVID-19 continue to shelter in place. DBHDD recommends that all DBHDD authorized providers of I/DD community access and pre-vocational services abide by this order and recommends that those providers not reopen community services before the shelter in place order for these populations has expired or been lifted. (Currently, the order is set to expire on June 12, 2020.) However, as we approach that date, it is expected that providers will be planning for an eventual reopening of services. The document below offers guidance to assist in planning to keep individuals, provider staff, and families safe.

Click here to access the document for more information regarding the reopening recommendations.

Stay tuned for announcements of upcoming webinars to discuss these recommendations with I/DD Providers.

APPENDIX K Operational Guidance

The DBHDD Division of Developmental Disabilities has updated the Appendix K Operational Guidelines. Please visit DBHDD PolicyStat for the most current update or you may click the link below.



COVID-19 2020: DBHDD Community Developmental Disability Services Policy Modifications - 4/30/2020

APPENDIX K Webinar Presentations

Below are the PowerPoint presentations from the IDD webinars regarding the Appendix K and the Operational Guidance. These presentations were sent out previously in a Special Bulletin on April 24th however, there is one new addition, a presentation that was held with Support

IDD PROVIDER WEBINAR - 4/15/20

SUPPORT COORDINATION WEBINAR - 4/16/20

BILLING PRESENTATION WEBINAR - 4/23/20

SUPPORT COORDINATION WEBINAR - 5/5/20

Office of Provider Relations

Director

Lynn Copeland

Senior Provider Relations Manager

Carole Crowley

Provider Relations Managers

Sharon Pyles Tim Strickland Lisa Sweat



For Provider Relations inquiries, please contact us at DBHDD.Provider@dbhdd.ga.gov

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IMPORTANT ANNOUNCEMENTS

Behavioral Health Billing Guidance Group Services Telehealth Allowances I/DD Webinar on Thursday

BEHAVIORAL HEALTH **Community Support Team & Community Support Individual Billing Guidance**

DBHDD has recently been made aware there are billing issues with Community Support Team (CST) and Community Support Individual (CSI) when it is delivered and billed via the telehealth allowance as set forth in DBHDD's communication on March 14 (Revised March 19), 2020. Upon research with our partners at the Department of Community Health (DCH) and the Georgia Collaborative ASO, these are programming anomalies which occurred Fall 2017, but due to limited telemedicine volume, were never discovered until the COVID-19 telehealth allowances were enacted.

The assessment and solution guidance for each service are offered in the memo available by clicking here.

BEHAVIORAL HEALTH Group Services & Telehealth Allowances

Based on reflections from the provider network regarding emerging practice experience, effective May 11, 2020, DBHDD will remove the "no more than 6 participants" constriction related to the provision of behavioral health groups conducted via telehealth. DBHDD will allow agencies, along with their clinicians, to consider the service model and targeted participants, exercising their best clinical judgement in designing the ratio of practitioner to individuals served. However, the ratio must comply with the ratio that exists in the current service guidelines within the DBHDD Community Behavioral Health Provider Manual.

DBHDD will also now allow for blended group modalities (for instance, some individuals attending group in person and some joining group via Zoom). Again, the practitioner to individuals-served ratio that exists within current service guidelines must be adhered to. Again, this should be considered only when the agency and clinician have given consideration to the participants needs and capacities as well as the subject for the group, tolerance for technology, etc. A graphic representation of this is provided below.



I/DD APPENDIX K WEBINAR & Community Settings Reopening Guidance

The DBHDD Division of I/DD will be hosting a Webex discussion about Appendix K as well as the DBHDD Community Settings Reopening Guidance. This meeting is for DBHDD network providers. Please plan to join this information session.

Date: Thursday, May 21, 2020 Time: 10:00am – 11:30am

NOTE: This session will utilize the Webex webinar online conferencing system. Webex allows participants to log on to a website from their computer, view the facilitators information online, while listening to the facilitator through the use of a simultaneous telephone conference call.

All participants must use the link below to register for the webinar. Additionally, please note that it is strongly encouraged that you join the webinar at least 15 minutes prior to the start time to ensure that you do not experience any connectivity issues. Although all attendees will be muted, the chat box will be functional, and all attendees are encouraged to ask questions and share thoughts through the interactive chat. The facilitator will allot time for Q&A at the end of the presentation.

Registration is quick and easy online, click here to register.

Questions? Please email DBHDDLearning@dbhdd.ga.gov.

DBHDD invites you to participate in our **2x2 Series: Daily Self-Care Tips and Support for Health Care and Emergency Response Workers**. These WebEx events are designed to provide daily self-care tips and support for health care and emergency response workers. Each session will provide attendees with mental health tips about managing stress, grief, work/life balance, and wellness.

NOTE: The sessions will use the WebEx webinar online Conferentifics yste088 WebEx allows: participants to 3 og drilled 1: a website from their computer and view the facilitator's information online, while listening to the facilitator through the use of a simultaneous telephone conference call.

Below is the date, time, session title and registration link for the next five sessions (the password for each session is "2by2"):

- May 18, 2020 2:00 to 2:30 p.m.: 2x2 Series: A Guided Meditation Exercise
- May 19, 2020 2:00 to 2:30 p.m.: 2x2 Series: Crafting Your Mental Health
- May 20, 2020 2:00 to 2:30 p.m.: 2x2 Series: How to Use Your Personality as a Hint to the Best Self-Care
- May 21, 2020 2:00 to 2:30 p.m.: 2x2 Series: Mindfulness Techniques to Manage Stress - Part 2
- May 22, 2020 2:00 to 2:30 p.m.: 2x2 Series: Personal Wellness: Prioritize You!

If you cannot attend the live sessions, each one will be recorded and available for review on the DBHDD website: https://dbhdd.georgia.gov/2x2-series.

All participants must use the links below to register for the 2x2 sessions. Additionally, please note that it is strongly encouraged that you join the webinar 10-15 minutes prior to the start time to ensure that you do not experience any connectivity issues. Although all attendees will be muted, the chat box will be functional, and all attendees are encouraged to ask questions and share thoughts through the interactive chat. The facilitator will allot time for Q&A at the end of the presentation.

Questions? Please email DBHDDLearning@dbhdd.ga.gov.

Office of Provider Relations

Director

Lynn Copeland

Senior Provider Relations Manager

Carole Crowley

Provider Relations Managers

Sharon Pyles Tim Strickland Lisa Sweat



29/23 • Page 593 of 62

Daily Self-Care Tips & Support for Health

For Provider Relations inquiries, please contact us at DBHDD.Provider@dbhdd.ga.gov

BE WELL





DBHDD has recently been made aware there are billing issues with Community Support Team and Community Support Individual when it is delivered and billed via the telehealth allowance as set forth in DBHDD's communication on March 14 (Revised March 19), 2020. Upon research with our partners at DCH and the ASO, these are programming anomalies which occurred Fall 2017, but due to limited telemedicine volume, were never discovered until the COVID-19 telehealth allowances were enacted.

The following assessment and solution guidance for each service are offered below:

COMMUNITY SUPPORT TEAM:

<u>Identified Problem:</u> CST does not have the GT modifier added in the ASO system. This means when CST has been authorized, the telemedicine modifier is not being sent to GAMMIS on authorizations, creating an inability for the claim to match with an existing authorization.

<u>Identified Solution</u>: For Medicaid claims, DCH has indicated the POS 02 is allowable and programmed for these codes below now, so the provider is able to bill (or resubmit now) for telehealth adding the POS 02 to one of the codes in this chart:

CST	H0039	TN	U3	U6
CST	H0039	TN	U4	U6
CST	H0039	TN	U5	U6
CST	H0039	TN	U3	U7
CST	H0039	TN	U4	U7
CST	H0039	TN	U5	U7

For state-funded claims, Place of Service (02) is being added to CST in the ASO's Provider Connect system. For state-funded individuals receiving this service, as above, providers must add 02 POS to the claim for reimbursement/reporting. While this is not active in the ASO system yet, work is underway for that fix with an effective date retroactive to March 2020.

COMMUNITY SUPPORT INDIVIDUAL:

Identified Problem: In the ASO and GAMMIS system, the GT codes were added without the 'U6' modifier. If the Providers used the programming tables released by DBHDD in Fall 2017, there should be no problem with the claiming (only providers who have used the Behavioral Health Provider Manual coding instead of the official IT Programming coding will likely experience this billing problem).

<u>Identified Solution</u>: Providers will need to bill for CSI provided via telehealth using the GT codes below in yellow:

H2015	U4	U6	
H2015	U5	U6	
H2015	U4	U7	
H2015	U5	U7	
H2015	GT	U4	
H2015	GT	U5	
H2015	UK	U4	U6
H2015	UK	U5	U6
H2015	UK	U4	U7
H2015	UK	U5	U7
	H2015 H2015 H2015 H2015 H2015 H2015 H2015 H2015	H2015 U5 H2015 U4 H2015 U5 H2015 GT H2015 GT H2015 UK H2015 UK	H2015 U5 U6 H2015 U4 U7 H2015 U5 U7 H2015 GT U4 H2015 GT U5 H2015 UK U4 H2015 UK U4 H2015 UK U5 H2015 UK U5

NETWORK BULLETIN



IMPORTANT ANNOUNCEMENTS

Behavioral Health Provider Manual Update to Fingerprinting Process Image

Provider Manual for Community Behavioral Health Providers

In order to historically document DBHDD communications, policy, and guidance issued to providers during the COVID-19 Public Health Emergency (PHE), the DBHDD will be reposting revisions to certain versions of the **Provider Manual for Community Behavioral Health Providers** that were in effect during the PHE. The revisions will include a new Appendix E at the end of each applicable Provider Manual that catalogs and appends all communications, policy, and guidance issued during the effective dates of the Manual, in chronological order. Currently, two versions of the Provider Manual will be revised:

- 1. The FY20, Quarter 3 (effective January 1, 2020 through March 31, 2020) Provider Manual will contain all PHE-related content released between March 1st and March 31st.
- 2. The FY20, Quarter 4 (effective April 1, 2020 through June 30, 2020) Provider Manual will contain all PHE- related content released between March 1st and May 31st (this Manual may again be revised and reposted if new content is released in June).

Given the uncertainty regarding expiration dates of both the PHE itself and of the various federal allowances made under the PHE, the regularly scheduled upcoming FY21, Quarter 1 Provider Manual (effective July 1, 2020 through September 30,2020), which will be posted to the DBHDD website on June 1st, will not contain the PHE-related content.

As the DBHDD continues to engage with state and federal authorities related to the PHE and its related allowances, there will be a revision and reposting of this Provider Manual between June 1st and July 1st if the PHE and its allowances do in fact continue as of July 1 st. Further revisions and repostings may also occur as PHE-related content expires or is added during this Provider Manual's effective dates.

UPDATE! Change in Fingerprinting Process

The Gemalto Cogent, Georgia Application Processing Service for fingerprint background requests, will launch its website redesigned effective June 1, 2020. As a result, there will be a new process when processing the fingerprint background applications for the DBHDD Provider Network. The Provider Network will have to complete a form and cover letter in its

entirety in order to process fingerprint background applications. Both forms will be mandatory-for-processing Clicotheringhoddow to access the 1429/2012 documents 97 of 627

GEMALTO FORM & COVER LETTER

IMAGE Browser Compatibility for Data Entry

Microsoft Internet Explorer is being replaced by Microsoft Edge. We recommend using either Edge or Chrome browsers for data entry in Image. If you use Microsoft Internet Explorer, you may encounter user interface (UI) elements not working as intended, such as issues entered the date and time of an incident. If you run into this issue, please switch browsers and the issue generally resolves. Any other user issues can be sent to Image.App@dbhdd.ga.gov and we will do our best to assist you.

Office of Provider Relations

Director

Lynn Copeland

Senior Provider Relations Manager

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Provider Relations Managers

Sharon Pyles Tim Strickland Lisa Sweat



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 Current Status: Active
 PolicyStat ID: 8366536

 Creation:
 3/26/2020

 Effective:
 7/24/2020

 Last Reviewed:
 7/24/2020

Georgia Department
of Behavioral Health
& Developmental

D.B.H.D.D
Disabilities

Cowner: More

Owner: Monica Johnson, MA, LPC:

Director, Division of Behavioral

7/24/2020

1/20/2021

Health

Chapter: Admin Issues for BH & DD

Services

Sections:

COVID-19 2020: DBHDD Community Behavioral Health Services Policy Modifications - 7/24/2020

EFFECTIVE IMMEDIATELY

APPLICABILITY

DBHDD Providers of Community Behavioral Health Services

POLICY

In response to the continued transmission of COVID-19, where necessary new measures are in effect to minimize community spread of the virus, and to assist in the continued delivery of community behavioral health services.

Modifications as described in this policy refers to the restriction, enhancement, relaxation, and partial or full suspension of existing policies in PolicyStat, as applicable to the service. This policy includes full details of the alternate requirement(s) or procedures.

The following temporary modifications to the policies listed below are pertinent to community behavioral health services, effective immediately. Please refer to the full policy via the hyperlink, noting the alternate requirements applicable until further notice.

This policy will be updated as necessary. This policy remains in effect until the Governor of the State of Georgia lifts the Emergency Declaration.

- Temporary enhancements are made to the requirements stated in <u>CSU: Medical</u> <u>Evaluation Guidelines and Exclusion Criteria for Admission to Crisis Stabilization Units</u>, <u>01-350</u>
 - a. Section A
 - A new version of the Medical Evaluation Guidelines & Exclusion Criteria for Persons Referred for Admission to Crisis Stabilization Units (Attachment A). See Item 9 which allows quarantine or isolation as needed to treat COVID positive individuals.
 - Section D.3
 COVID-19 positive status cannot be the sole reason for denial of care. Additional input and documentation from CSU Medical Director and Leadership is required for a denial.

- 2. A temporary enhancement is made to CSU: Evaluations and Admissions, 01-330:
 - a. CSUs refer to the 7/24/2020 version of Attachment A (Exclusionary Criteria) of 01-350, to allow isolation or quarantine as needed to ensure continued access as required of an Emergency Receiving and Evaluating facility.
- 3. Behavioral Health Providers categorized as Tier 1 or Tier 2 are required to adhere to standards and key performance indicators as outlined in <u>Comprehensive Community Provider (CCP) Standards for Georgia's Tier 1 Behavioral Health Safety Net, 01-200</u> and <u>Community Medicaid Provider (CMP) Standards for Georgia's Tier 2 Behavioral Health Services, 01-230</u>. Due to the impact of the COVID-19 pandemic, DBHDD has delayed the reporting requirements outlined in <u>Process for Reporting Compliance with Standards for Tier 1 Comprehensive Community Providers (CCPs), 01-225, Process for Reporting Compliance with Standards for Tier 2 Community Medicaid Providers (CMPs), 01-249, Process for Reporting Compliance with Standards for Tier 2 Community Medicaid Providers (CMP+), 01-249a, and <u>Standards and Key Performance Indicators for Providers of Community Crisis Services, 01-270</u>. A *temporary relaxation* of the report due dates is permitted as follows:</u>
 - a. Tier 1, Tier 2, Tier 2+, and Community Crisis Services
 The reporting due date for the "Performance Monitoring Report" (PMR) has been
 extended to October 1, 2020. The reporting period will remain the same (July 1, 2019 –
 June 30, 2020). The PMR portal will open for providers September 1, 2020.
 - Tier 1
 Activities related to community stakeholder surveys will be delayed and not initiated until the summer.
 - c. In the following reporting year the reporting schedule outlined in <u>01-225</u>, <u>01-249</u>, <u>01-249a</u>, and <u>01-270</u> will resume.
- 4. **Temporary suspension** of the site visit requirement for behavioral health provider enrollment, per <u>Recruitment and Application to become a Provider of Behavioral Health Services</u>, 01-111 are permitted as follows:
 - a. New Applicants
 - i. Site visits are currently suspended for new providers. Applications for new providers will remain in a pending status until site visits resume.
 - b. Existing Providers
 - i. Site visits for new sites are suspended. Site visits will be waived for existing DBHDD approved providers applying for services at an existing approved site or a site that is currently licensed by Healthcare Facility Regulation (HFR). Pending applications that require a site visit and do not meet these criteria will remain in pending status until site visits resume.
 - c. Applicant Forum
 - i. Applicants must have attended one of the two most recent BH Provider Enrollment Forums (held August 14, 2019 and December 11, 2019) to be eligible to submit a Letter of Intent (LOI) during this enrollment cycle. LOIs must be submitted to the Georgia Collaborative via email at GA_Enrollment@Beaconhealthoptions.com.

recommended to submit LOIs via email.

LOIs submitted before May 1 or after May 31 will not be accepted or processed. LOIs submitted via USPS mail may experience delays in processing. It is highly

- 5. A *partial suspension* of the fingerprinting requirement described in Criminal History Record Check for DBHDD Network Provider Applicants, 04-104 is permitted as described below only if fingerprinting services are not available in your area:
 - a. DBHDD's Provider Network must have each person subject to Policy 04-104 complete the "Network Provider Applicant Attestation," Attachment A to this policy, instead of completing the fingerprint based background check stipulated in Policy 04-104.
 - b. Within sixty (60) days of cessation of the Public Health Emergency, all persons who signed the Network Provider Applicant Attestation instead of completing the fingerprint based background check must complete a fingerprint based background check as required by Policy 04-104. The provider is responsible for sending any person who signed the Network Provider Applicant Attestation for a fingerprint based background check.
 - c. The provider is also responsible for sending to DBHDD's Criminal History Background Check (CHBC) section each signed Network Provider Applicant Attestation, while retaining a copy in the applicant's personnel file. The provider must send the signed and dated Attestation to CHBC, and acknowledge receipt of an email from CHBC confirming acceptance of the Attestation, before the applicant begins working. The Individual Assessment process set forth in section D of Policy 04-104 does not apply to persons who sign the Network Provider Applicant Attestation.
 - d. The Attestation cannot be used by Network Provider Applicants who were fingerprinted for a fingerprint- based background check within sixty (60) days prior to the declaration of the Public Health Emergency.
- 6. A *partial suspension* of the income verification requirements using tax returns, pay check stubs, verification of benefits from other federal or state agencies as stipulated in Sections B.3 and F.2 of Payment by Individuals for Community Behavioral Health Services, 01-107 has been made as follows:
 - a. For the period of the Public Health Emergency related to COVID-19, DBHDD waives the requirement for income verification to access state funded behavioral health services.
 - b. Provider agencies are required to request attestation of income from individuals served and verify authenticity to the best of their ability.
 - i. If verification is unavailable due to resource constraints related to COVID-19, providers are required to note this in the record. At the end of the public health emergency, providers will be required to verify individuals income status within 90 days.

DBHDD sincerely appreciates your compliance with these measures throughout this Public Health Emergency.

Attachments

A - COVID-19 2020 - Attestation of Absence of Barrier Crimes Data & Cover Letter 4/23/2020.docx

Approval Signatures

Approver	Date
Anné Akili, Psy.D.: Director, Policy Management	7/24/2020
Monica Johnson, MA, LPC: Director, Division of Behavioral Health	7/24/2020
Anné Akili, Psy.D.: Director, Policy Management	7/24/2020





Georgia Department of Behavioral Health & Developmental Disabilities

Judy Fitzgerald, Commissioner

Office of Enterprise Compliance

Two Peachtree Street, NW • 1st Floor • Atlanta, Georgia 30303-3142 • Telephone: 404-463-2507 • Fax: 770-359-5473

I,					
, -	Last Name	First Nam	e	Middl	e Initial
	Social Security No.	Height	Weight	Eye color	Hair Color
	Date of Birth	Sex		Race	
	Street Address		City	State	Zip

attest that I have not been convicted of nor have pending charges for any crime listed on Barrier Record Data (Attachment D of <u>Criminal History Record Check for DBHDD</u> <u>Network Provider Applicants</u>, 04-104, a copy of which has been provided to me).

I also attest that:

- 1. I am not currently on probation as a First Offender for a crime listed on Barrier Record Data (Attachment D);
- 2. I am not awaiting final disposition on charges for any crime referenced on the Barrier Record Data (Attachment D);
- 3. I do not knowingly have an outstanding warrant for any crime referenced on the Barrier Record Data (Attachment D);
- 4. I do not have a finding of guilty but mentally ill (GBMI) for any crime referenced on the Barrier Record Data (Attachment D);
- 5. I do not have a finding of guilty with intellectual disability (GWID) for any crime referenced on the Barrier Record Data (Attachment D); and
- 6. I do not have a finding of not guilty by reason of insanity (NGRI) for any crime referenced on the Barrier Record Data (Attachment D).
- 7. I do not have any convictions within the last 12 months.

This form serves as a contingency for employment. Within sixty (60) days of the termination of the Public Health State of Emergency, I understand that I will be required to complete a fingerprint based background check and if any information stated hereon is found to be falsified or untrue, I could be deemed ineligible for continued employment by a DBHDD network provider. I also understand that prior to being fingerprinted, if any information stated hereon is discovered to have been falsified or is found to be untrue, I could be deemed ineligible for continued employment.

Signature		
Date		



TO:

Georgia Department of Behavioral Health & Developmental Disabilities

 $\it Judy$ Fitzgerald, Commissioner

Office of Enterprise Compliance

Two Peachtree Street, NW • 1st Floor • Atlanta, Georgia 30303-3142 • Telephone: 404-463-2507 • Fax: 770-359-5473

FROM: DBHDD Office of Enterprise Compliance
Criminal History Background Checks Section

DBHDD Provider Network

RE: Policy No. 04-104 Attestation

Immediately after a person subject to Policy No. 04-104, as modified during the Public Health State of Emergency, completes the Attestation required under the modified policy, send the Attestation to CHBC by facsimile to (770) 359-1622, or via email at **DBHDD-CRS@DBHDD.GA.GOV.** with this Cover Sheet after completing the information required below:

Provider Name	
Name of Direct Contact	
Contact Phone Number	
Email address	

If you have questions, please contact our office at 404-463-2507 or 404-232-1641.







IMPORTANT ANNOUNCEMENT Image Incident Reporting Changes

IMAGE COVID-19 Incident Reporting Changes

As we continue to navigate working and supporting our individuals during the current pandemic, we recognize that the current way of reporting COVID incidents is untenable. As such, the changes below are being implemented immediately. Hopefully this will help bring some relief to those completing data entry in the system.

FOR DD RELATED SERVICES:

Entries in Image for 920 – Exposure are ONLY REQUIRED FOR INDIVIDUALS. Reporting of staff exposures is no longer required.

Entries in Image for 921 – Positive, and 922 – Death ARE STILL REQUIRED for both staff and individuals.

Entries in Image for 923 – Recovery will no longer be required for individuals or staff at any locations.

	920 Exposed	921 Positive	922 Death	923 Recovery
Staff	Not required	REQUIRED	REQUIRED	Not required
Individual	REQUIRED	REQUIRED	REQUIRED	Not required

DD Providers should continue to work with the DBHDD Office of Health and Wellness staff who will maintain follow-up activities on individuals who test positive until that individual is no longer identified as being positive for COVID 19 or in the event of death, reported as deceased. (Note: Resolution of positive will be based upon CDC Guidelines for designation of COVID 19 negative status.)

FOR BH RELATED SERVICES INCLUDING CSU/BHCC:

Entries in Image for incident types 920 – Exposure and 923 – Recovery will no longer be required for individuals or staff at any locations.

Entries in Image for 921 – Positives and 922 – Deaths ARE STILL REQUIRED for both staff and individuals.

	920 Exposed	921 Positive	922 Death	923 Recovery
Staff	Not required	REQUIRED	REQUIRED	Not required
Individual	Not required	REQUIRED	REQUIRED	Not required

Submitted by:

Jennifer Rybak, Director
Office of Incident Management and Compliance

Office of Provider Relations

Director

Lynn Copeland

Senior Provider Relations Manager

Carole Crowley

Provider Relations Manager

Sharon Pyles



For Provider Relations inquiries, please contact us at DBHDD.Provider@dbhdd.ga.gov

BE WELL, WEAR A MASK & WASH YOUR HANDS!





Current Status: Active PolicyStat ID: 8618576

Georgia Department of Behavioral Health & Developmental Disabilities

Creation: 3/26/2020
Effective: 9/21/2020
Last Reviewed: 9/21/2020
Last Revision: 9/21/2020
Next Review: 3/20/2021

Owner: Monica Johnson, MA, LPC:

Director, Division of Behavioral

Health

Chapter: Admin Issues for BH & DD

Services

Sections:

COVID-19 2020: DBHDD Community Behavioral Health Services Policy Modifications - 9/21/2020

EFFECTIVE IMMEDIATELY

APPLICABILITY

DBHDD Providers of Community Behavioral Health Services

POLICY

In response to the continued transmission of COVID-19, where necessary new measures are in effect to minimize community spread of the virus, and to assist in the continued delivery of community behavioral health services.

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1. Providers are expected to maintain accreditation as indicated in <u>Accreditation and Standards Compliance Requirements for Providers of Behavioral Health Services</u>, 01-103. It is understood that some accreditation surveys and reviews may be impacted by the COVID-19 Public Health Emergency. Based on the accrediting body, providers may find that their accreditation reviews are conducted online or with minimal on-site time. In addition, reviews may be postponed by the accrediting body and an extension offered due to COVID-19. Should the later occur, DBHDD will honor the extension offered by the accrediting body for a period not to exceed 180 days following the end of the National Public Health Emergency. Providers may be asked to provide proof of extension to demonstrate compliance.

- 2. **Temporary enhancements** are made to the requirements stated in <u>CSU: Medical</u> Evaluation Guidelines and Exclusion Criteria for Admission to Crisis Stabilization Units, 01-350
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 A new version of the Medical Evaluation Guidelines & Exclusion Criteria for Persons
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 COVID-19 positive status cannot be the sole reason for denial of care. Additional input and documentation from CSU Medical Director and Leadership is required for a denial.
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i. Site visits for new sites are suspended. Site visits will be waived for existing DBHDD approved providers applying for services at an existing approved site or a site that is currently licensed by Healthcare Facility Regulation (HFR). Pending applications that require a site visit and do not meet these criteria will remain in pending status until site visits resume.

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- i. Applicants must have attended one of the two most recent BH Provider Enrollment Forums (held August 14, 2019 and December 11, 2019) to be eligible to submit a Letter of Intent (LOI) during this enrollment cycle. LOIs must be submitted to the Georgia Collaborative via email at GA Enrollment@Beaconhealthoptions.com. LOIs submitted before May 1 or after May 31 will not be accepted or processed. LOIs submitted via USPS mail may experience delays in processing. It is highly recommended to submit LOIs via email.
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 - d. The Attestation cannot be used by Network Provider Applicants who were fingerprinted for a fingerprint- based background check within sixty (60) days prior to the declaration of the Public Health Emergency.
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and verify authenticity to the best of their ability.

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Attachments

A - COVID-19 2020 - Attestation of Absence of Barrier Crimes Data & Cover Letter 4/23/2020.docx

Approval Signatures

Approver	Date
Anné Akili, Psy.D.: Director, Policy Management	9/21/2020
Monica Johnson, MA, LPC: Director, Division of Behavioral Health	9/21/2020
Anné Akili, Psy.D.: Director, Policy Management	9/21/2020

NETWORK NEWS "News You Can Use"



Appendix K Attestation Form

DEADLINE OCTOBER 1, 2020

The deadline for New Options Medicaid Waiver and Comprehensive Supports Medicaid Waiver (NOW/COMP) Providers as well as Representatives for individuals enrolled in the Participant-direction model for



the NOW/COMP Medicaid Waiver services to submit their Appendix K Attestation is on Thursday, **October 1, 2020**.

All provider agencies that received a retainer payment for any of the approved services must complete an Attestation Statement indicating compliance with the Centers for Medicare and Medicaid Services (CMS) requirements.

The attestation form is available on the **Department of Community Health website.** Once there, locate the **"Medicaid and Peachcare for Kids"** navigation pane. In that navigation pane click on the **"Provider agencies retainer payment attestation form"** link to access the required form.



In response to the growing need for citizens of Georgia to access behavioral health support and resources during the current health crisis, the Department of Behavioral Health & Developmental Disabilities (DBHDD) in partnership with Behavioral Health Link (BHL) implemented the GA COVID19 emotional support line. This statewide support line is an expansion of the already existing Georgia Crisis and Access Line (GCAL). The Georgia COVID19 Emotional Support Line provides free and confidential assistance to callers needing emotional support, community resources, or referrals to service providers in their communities. The Emotional Support Line is staffed with mental health professionals and others who have received training in crisis counseling. This crisis is causing people to experience a myriad of emotions and the GA COVID19 Emotional Support Line offers Georgians another option for receiving support in managing their reactions and experiences to the COVID19 crisis.

Thus far, callers have been able to receive non-crisis related assistance in helping them

manage feelings of loneliness and isolation, as well as stress and anxiety. Callers have also been able to receive the covered by the covered

Click here to access additional mental wellness resources and supports.

DBHDD Policy Information

Since September 1, 2020 DBHDD updated or developed the following policies:

Corrective Action Plan Management, 13-101

COVID-19 2020: DBHDD Community Behavioral Health Services Policy Modifications - 9/21/2020

COVID-19 2020: DBHDD Community Developmental Disability Services Policy Modifications - 9/21/2020

Provider Manual for Community Behavioral Health Providers, 01-112

Provider Manuals for Community Developmental Disability Providers, 02-1201

Recruitment and Application to become a Provider of Behavioral Health Services, 01-111

All current policies can be found on PolicyStat.

Please direct all policy-related questions to the Office of Provider Relations via the Provider Issues Management System (PIMS). To submit your questions **click here**.

Training Announcements

DBHDD IN-PERSON TRAININGS POSTPONED

In response to the coronavirus (COVID-19) in Georgia, and Governor Kemp's Public Health State of Emergency guidance to cancel or postpone all non-essential travel, DBHDD is postponing **in-person trainings**. The health, safety and well-being of the individuals we serve, practitioners, and staff are DBHDD's top priority, and this decision has been made with those in mind. DBHDD is closely monitoring related developments and will provide additional information and updates related to these events in the coming weeks. Thank you for your interest and event registration, and most importantly, your dedication and commitment to those we serve.

It's important to note that DBHDD is offering virtual trainings, for information regarding these virtual trainings, click here.

If you have any questions, please contact DBHDD.Learning@dbhdd.ga.gov.

DBHDD Announcements

Human Trafficking Intervention Services and Support Hotline

Page 612 of 627

As you may be aware, Georgia Cares has previously managed a hotline to provide information to those who might be victims of trafficking, assist law enforcement on the recovery of a victim, and make referrals for victim assistance. **Beginning October 1, 2020**, a new hotline — **1-866-END-HTGA** (or 1-866-363-4842) will now be managed by the Children's Advocacy Centers of Georgia (CACGA) as they assume the role as the statewide provider for



human trafficking intervention services and support. If you are aware of youth who have previously been served by Georgia Cares and are concerned they may no longer receive such services, please ensure they are connected with CACGA by calling the hotline number. While the transfer officially occurs on October 1, this line is currently active. This hotline also offers connections to additional resources related to preventing and intervening in trafficking cases.

Referrals to CACGA may result in a further response or intervention from a local Child Advocacy Center (CAC) or the **Receiving Hope Center**.

The DBHDD COVID policies COVID-19 2020: DBHDD Community Behavioral Health Services Policy Modifications - 9/21/2020 and COVID-19 2020: DBHDD Community Developmental Disability Services Policy Modifications - 9/21/2020 have been updated with an effective date of September 21, 2020.



These policies were updated to address concerns regarding the requirements of maintaining current Provider accreditation during the public health emergency. The following statement was added to both policies:

Providers are expected to maintain accreditation as indicated in Accreditation and Compliance Review Requirements for Providers of Developmental Disability Services, 02-703 or Accreditation and Standards Compliance Requirements for Providers of Behavioral Health Services, 01-103. It is understood that some accreditation surveys and reviews may be impacted by the COVID-19 Public Health Emergency. Based on the accrediting body, providers may find that their accreditation reviews are conducted online or with minimal on-site time. In addition, reviews may be postponed by the accrediting body and an extension offered due to COVID-19. Should the later occur, DBHDD will honor the extension offered by the accrediting body for a period not to exceed 180 days following the end of the National Public Health Emergency. Providers may be asked to provide proof of extension to demonstrate compliance.

FRAUD ALERT! Department of Justice Impersonators

Attention all DBHDD Providers scammers are falsely claiming to be employees and/or investigators for the Department of Justice (DOJ) in order to obtain personal identifying information. We ask



that providers utlize the brochure, available here, to increase awareness about this concern.

For more information, please read the article - *Fraud Alert: Scammers Claiming to be with DOJ, Preying on Elderly.*

Project Provides Emotional Case 1:16-cv-03088-ELR Document 448-73 Support to Georgians During COVID-19

Georgia CCVID-19
Emotional Support Line
866-399-8938

Total Control Co

The Georgia Department of Behavioral Health and Developmental Disabilities was awarded a

Federal Emergency Management Administration Crisis Counseling Assistance and Training Program (CCP), called the Georgia Recovery Project, to assist Georgians with emotional distress from COVID-19.

The CCP helps individuals and communities in recovering from the effects of natural and human-caused disasters through the provision of community-based outreach and psychoeducational services. Because of social distancing due to the pandemic, this is done through virtual outreach by crisis counselors working in DBHDD's six Regions and staff working on Georgia's COVID-19 Emotional Support Line at 866-399-8938.

Georgia Recovery Project staff provide a "listening ear" for concerned individuals who want to talk about how they've been affected by the pandemic. They also provide psycho-education on stress management, referrals to community-based services for basic needs and direct linkage to crisis services when warranted. The Georgia Recovery Project will run until June 15, 2021. Information about the CCP may be found at https://www.samhsa.gov/dtac/ccp.

Submitted by:
Jeannette David, Disaster Mental Health Coordinator
Division of Behavioral Health

Developmental Disabilities

Intellectual and Developmental Disabilities Statewide Provider Meeting





Stay tuned for additional information to be distributed by the Office of Provider Relations via Special Bulletin, which will include the registration link and the meeting agenda.

DCH and DBHDD Virtual Town Hall Meetings

The Department of Community Health (DCH) and DBHDD are co-hosting a series of virtual town hall meetings for the 2021 Comprehensive Supports (COMP) Medicaid waiver renewal. The DBHDD and DCH will be providing updates on



the COMP Medicaid waiver renewal, providing updates on recent waiver amendments, and seeking input from the community and stakeholders. The event is open to the public. Registration is required.

- Monday October 26, 2020 (8:30 am 9:30 am)
- Tuesday October 27, 2020 (12:00 pm 1:00 pm)

• Thursday October 29, 2020 (5:30 pm – 6:30 pm)

Case 1:16-cv-03088-ELR Document 448-73 Filed 11/29/23 Page 614 of 627

This meeting will be online via WebEx at the dates and times listed above. You will only need to attend **ONE** session, as they will all include the same information. There will also be time allotted for questions and answers at the end of the town hall.

Click here to register for the event.

Behavioral Health

New Diagnosis Codes Effective 10/1/2020 for Substance Use Disorders

The Georgia Collaborative ASO notified providers on September 21, 2020 of new diagnosis codes that will be implemented on 10/1/2020. These codes were recently released by the Centers for Medicare and Medicaid Services (CMS) and are all **related to substance use disorders**.

Please review the **memorandum** for more information regarding these changes.

ProviderConnect Service Changes Crisis Respite & Community Residential Rehab-Level 4

The Georgia Collaborative ASO notified providers on September 16, 2020 about service changes being made in the ProviderConnect system. They outlined changes being made to the Crisis Respite Apartment service and which was retroactive to 7/1/2020. There was additional information related to the Community Residential Rehabilitation - Level 4 service. This information was only applicable to those behavioral health providers approved for Crisis Respite or Community Residential Rehab - Level 4.

Please review the **memorandum** for more information regarding these changes.

Join the Youth Mental Health Awareness Campaign

September was National Suicide Prevention Awareness Month, and what better time to launch our youth mental health awareness campaign "Free Your Feels"? Free Your Feels encourages Georgia's young people to explore their real feelings and share them fearlessly. With our children and teens empowered to speak out and express their real feelings, adults and peers tuned in and listening judgment-free, and everyone connected to available resources, we will see a healthier, thriving generation.





Visit the Free Your Feels website which will house a collection of resources from different organizations and agencies, and will include ready-to-use editable graphics so you can easily promote and share messaging!

Follow @free.your.feels on Instagram, where we will share mental health materials. Share posts on your own account and/or ask people in your networks to follow and help spread the message far and wide!

Office of Provider Relations

PIMS CORNER

Welcome to the PIMS Corner! This section highlights the two most popular questions, and their answers, that were submitted to PIMS for the month of August 2020.



Look for this section each month as we will continue to feature one question each from Intellectual and Developmental Disabilities and Behavioral Health Providers.

Behavioral Health Question:

How do we request coupons for the Adult Needs and Strengths Assessment (ANSA) and the Child and Adolescent Needs and Strengths (CANS) assessment for our agency?

Unfortunately, free coupon codes for DBHDD Employees and Contracted Provider Agency Staff to access the online training modules and tests on the Praed Foundation website are **NOT** currently available. If you would like to purchase your own access code or your agency is interested in making a group purchase, email Michelle Fernando **mfernando@chapinhall.org** at Praed Foundation and provide her with the following information:

- Jurisdiction (Georgia)
- Agency name
- Method of payment (check or credit card)
- Number of codes needed

<u>Intellectual and Developmental Disabilities Question:</u>

Are the same procedure code and modifier used for teleheath services and the retainer payment?

On April 23,2020, DBHDD conducted a webinar for providers that offered technical assistance

JUST A REMINDER... Question for your Provider Relations Team?

The Provider Issues Management System (PIMS) is your online source to have your questions answered in a consistent, reliable and timely way! In addition to providing a timely response, the information we gather from PIMS will assist DBHDD in trending common concerns, developing FAQs, and informing policy reviews.

PIMS is accessible through the **DBHDD website** by hovering over the **"For Provider"** tab located across the top of the page. When the drop down menu appears, click on "**Questions for your Provider Relations Team**". You can also access the PIMS site directly by using the link below.

PROVIDER ISSUES MANAGEMENT SYSTEM

IN CASE YOU MISSED IT... highlights from previous bulletins

The Georgia Collaborative ASO Quality Reviews Update

The Quality Reviews conducted by the Georgia Collaborative ASO are an important and required aspect of DBHDD's role in the management of the provider network and a valuable tool for providers' monitoring of quality and compliance to DBHDD requirements. Due to COVID-19, DBHDD paused quality reviews in mid-March. The reason for this pause was two-fold; first, to relieve providers of the burden of a quality review while in the midst of a COVID emergency, and second, to comply with social distancing guidance. We have now passed the six month milestone. During this, we have all found new and creative ways to stay connected, accomplish our goals, and provide services and supports to individuals. As we navigate our altered environment, DBHDD, like you, is working to develop customized strategies to coexist with COVID.

DBHDD and the Georgia Collaborative ASO are thoughtfully planning a resumption of quality reviews; these will be conducted remotely for the time being. We, along with our partners at the Georgia Collaborative ASO, have developed a remote review process that we are currently piloting with three providers in order to field test and validate our processes. Once DBHDD has had time to consider and incorporate this valuable feedback from the pilot providers into our remote processes, we will resume quality reviews. Providers, as always, will receive a two week notice, and additional instructions and guidance to help them understand and prepare for the remote process.

The Office of Quality Improvement and Georgia Collaborative ASO hosted training sessions to outline the updated process on September 9, 2020 for both Behavioral Health and Developmental Disabilities Providers. The power point presentations and live recordings for both trainings are available on the Georgia Collaborative ASO website by clicking here. Once on the site, scroll down to "Quality" and then select either "Behavioral Health" or "Intellectual & Developmental Disabilities" to view the appropriate documents and recordings.

Thank you,

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Melissa Sperbeck, Director

Division of Performance Management & Quality Improvement

in partnership with

Monica Johnson, Director, Division of Behavioral Health & Ron Wakefield, Director, **Division of Developmental Disabilities**

The DBHDD policy Corrective Action Plan Management, 13-101 has been updated and has an effective date of September 1, 2020. The changes are designed to help streamline the process and reduce the burden on providers where possible, while continuing to support the correction of identified issues.

Highlights of the changes include:

Corrective Action Plans (CAP) are only required to be submitted to DBHDD for High or Critical Risk deficiencies.

- For Low or Moderate Risk deficiencies, providers will be asked to complete an Internal Corrective Action Plan that does not need to be submitted to DBHDD.
- A simple form for the Internal CAP is provided as Attachment A to the revised policy.

The "Measures of Effectiveness" field has been removed from the CAP form.

• Although providers won't report this to DBHDD, providers are still required to maintain compliance and sustained correction over time.

DBHDD may conduct follow-up reviews to verify compliance.

- This may include requesting records or conducting virtual or on-site visits.
- DBHDD may request a copy of the Internal CAP at any time.

Our hope is that through collaboration with providers during the CAP process, we will be able to assist them in reaching and maintaining compliance. The reduction in required formal CAP responses should allow providers to better allocate resources to fixing the issues identified and effectively implement corrections. The process of reaching an acceptable CAP should take less time, allowing findings to be successfully resolved faster.

As always, providers have a responsibility for correcting all findings and maintaining compliance with applicable policies, regulations, federal and state requirements, accepted standards of care and practice, provider manuals and accreditation bodies, as applicable, regardless off the CAP process. Any questions regarding the CAP process can be directed to CAP.Request@dbhdd.ga.gov.

Submitted by Jennifer Rybak **Director, Office of Incident Management and Compliance Division of Accountability and Compliance**



Image COVID-19 Incident Reporting Changes

As we continue to navigate working and supporting our individuals during the current pandemic, we recognize that the current way of reporting COVID incidents is untenable. As such, the changes below are being implemented immediately. Hopefully this will help bring some relief to those completing data entry in the system.



FOR DD RELATED SERVICES:

Case 1:16-cv-03088-ELR Document 448-73 Filed 11/29/23 Page 618 of 627 Entries in Image for 920 – Exposure are ONLY REQUIRED FOR INDIVIDUALS. Reporting of staff exposures is no longer required.

Entries in Image for 921 – Positive, and 922 – Death ARE STILL REQUIRED for both staff and individuals.

Entries in Image for **923 – Recovery** will **no longer be required** for individuals or staff at any locations.

	920 Exposed	921 Positive	922 Death	923 Recovery
Staff	Not required	REQUIRED	REQUIRED	Not required
Individual	REQUIRED	REQUIRED	REQUIRED	Not required

DD Providers should continue to work with the DBHDD Office of Health and Wellness staff who will maintain follow-up activities on individuals who test positive until that individual is no longer identified as being positive for COVID 19 or in the event of death, reported as deceased. (Note: Resolution of positive will be based upon CDC Guidelines for designation of COVID 19 negative status.)

FOR BH RELATED SERVICES INCLUDING CSU/BHCC:

Entries in Image for incident types 920 – Exposure and 923 – Recovery will no longer be required for individuals or staff at any locations.

Entries in Image for 921 – Positives and 922 – Deaths ARE STILL REQUIRED for both staff and individuals.

	920 Exposed	921 Positive	922 Death	923 Recovery
Staff	Not required	REQUIRED	REQUIRED	Not required
Individual	Not required	REQUIRED	REQUIRED	Not required

Thank you for your continued support in reporting the incident types as outlined above. If you have any questions, please reach out to us at **dbhddincidents@dbhdd.ga.gov** and we will assist you.

Submitted by:
Jennifer Rybak
Director, Office of Incident Management and Compliance
Division of Accountability and Compliance

Appendix K Tracking of Retainer Payments & Family Caregiver Hire Options Report

Below is a link to a memo addressing completion of the Appendix K Tracking of Telehealth, Retainer Payments, and Family/Caregiver Options Report" spreadsheet. This memo highlights instructions on how to complete the spreadsheet as well as additional information regarding the Department of Community Health (DCH) attestation requirements.

We ask all providers to read the memo and contact your local regional office if you have any questions.

Retainer Payments & Family Caregiver Hire OptionsReport Memo

Case 1: 16:00:03089-ELIRI e Document 04:48-73

Please be advised the management and coordination of the DBHDD/Relias online libraries, which include the Developmental Disabilities library and the Behavioral Health Paraprofessional and Mental Health Recovery libraries, has transferred from the University of Georgia-



Carl Vinson Institute of Government (CVIOG) to the DBHDD Office of Human Resources and Learning.

Any questions, concerns, or recommendations related to Relias access or the transition may be directed to **relias.admin@dbhdd.ga.gov.**

Submitted by: Theodore Carter, Jr., Senior Director DBHDD Learning

During the month of September, DBHDD held the 2x2 Series: Daily Self-Care Tips and Support for Health Care and Emergency Response Workers. This series was presented as Webex events and were designed to provide daily self-care tips and support for health care and emergency response workers. Each session provided attendees with mental health tips about managing stress, grief, work/life balance, and wellness.

If you could not attend the live sessions, each one was recorded and is available for review on the DBHDD website: https://dbhdd.georgia.gov/2x2-series.



Georgia's Peer2Peer Warm Lines Are Open!

Georgia's Peer2Peer Warm Line plans to continue 24/7 operation through this time. Even where services are able to continue without interruption, there are likely going to be behavioral health service consumers



who are at-risk for the Coronavirus who choose not to visit service providers, and the Warm Line is an option for them to stay connected and receive support. Warm Line calls are answered by Georgia Certified Peer Specialists and is funded by DBHDD.

The Peer2Peer Warm Line toll-free number is 888-945-1414.

More information can be found by **clicking here**.

Department of Public Health Coronavirus Hotline

With all the concerns surrounding the COVID-19 pandemic the State of Georgia is trying to help ease the minds of residents. Georgia officials have created a new hotline that is available to all residents. Georgians can call **1-844-442-2681** with questions or concerns about the coronavirus.



If you believe that you are experiencing symptoms of COVID-19 or have been exposed to the novel coronavirus, please contact your primary care doctor or an urgent care clinic. Please do

not show up unannounced at an emergency room or health care facility.

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For more information, click here.

Senior Provider Relations Manager

Carole Crowley

<u>Provider Relations Manager</u> Sharon Pyles

For Provider Relations inquiries, please contact us at DBHDD.Provider@dbhdd.ga.gov.



BE WELL, WEAR A MASK & WASH YOUR HANDS!





NETWORK BULLETIN



HHS Announces Phase 3 Provider Funds Distribution

The U.S. Department of Health and Human Services (HHS), through the Health Resources and Services Administration (HRSA), <u>announced</u> \$20 billion in new funding for providers on the frontlines of the coronavirus pandemic.

Under this Phase 3 General Distribution allocation, providers that have already received Provider Relief Fund payments will be invited to apply for additional funding that considers financial losses and changes in operating expenses caused by the coronavirus. Previously ineligible providers, such as those who began practicing in 2020 will also be invited to apply, and an expanded group of behavioral health providers confronting the emergence of increased mental health and substance use issues exacerbated by the pandemic will also be eligible for relief payments.

Providers can begin applying for funds on Monday, October 5, 2020.

Providers are encouraged to apply early.

Click <u>here</u> to link to the HHS website for additional information and instructions to apply.

National Public Health Emergency Extended

On October 2, 2020, the Secretary of HHS, Alex Azar, renewed the national public health emergency on Friday with an effective date of Oct 23 for a period of 90 days. The declaration can be seen here.

DPH Update: Georgia Personal Protective Equipment

In March, DPH launched a ReadyOp link to request Personal Protective Equipment (PPE) during the supply shortage. The PPE supply chain has recovered to a point where the big six (gowns, gloves, face shields, coveralls, surgical masks, and hand-sanitizer) are available in stores and through

distributors. Given the change in availability of PPE, the Georgia Emergency Markagenery-Home language tirtly (32MAFILES) 11/4 We3 Georgia 622 of 627 Department of Public Health (DPH) have reassessed the PPE support mission of the State's COVID-19 response plan.

Please note, at 11:59 PM on October 15, 2020, DPH will deactivate the Ready Op PPE link and process all requests for emergency resupply of PPE through county EMAs using the State's WebEOC resource request process. Additional information can be found here.

DBHDD encourages providers to assess PPE needs routinely and place orders with your suppliers in advance. If an emergency does occur, providers may contact the county Emergency Management Director and he/she will help them with WebEOC.

Office of Provider Relations

<u>Senior Provider Relations Manager</u> Carole Crowlev

<u>Provider Relations Manager</u> Sharon Pyles

For Provider Relations inquiries, please contact us at DBHDD.Provider@dbhdd.ga.gov.



BE WELL, WEAR A MASK & WASH YOUR HANDS!







Georgia Department of Behavioral Health & Developmental Disabilities

Judy Fitzgerald, Commissioner

Division of Behavioral Health

Memorandum

To: Community Behavioral Health Providers

From: Monica Johnson, Director

Division of Behavioral Health

Wendy White Tiegreen, Director

Office of Medicaid Coordination & Health System Innovation

Subject: Continuation of Telemedicine and Telephonic Service Allowances Post- COVID-19

Public Health Emergency (PHE)

Date: August 1, 2022

The purpose of this memorandum is to notify providers of the Georgia Department of Behavioral Health and Developmental Disabilities' (DBHDD's) upcoming policy changes and related practice guidance regarding ongoing telemedicine and telephonic service allowances for behavioral health services following the COVID-19 Public Health Emergency.

Based upon learnings from the standards and practice utilized during the PHE, and practice reflections from the field and families/individuals served¹, the DBHDD will be expanding its policy regarding telemedicine/telephonic allowances for outpatient services falling within the purview of the DBHDD's authority, in order to substantially broaden the potential for telemedicine/telephonic intervention².

Along with these new flexibilities, there will also be some practice expectations that are intended to ensure the best possible experience related to telehealth practice for the people we serve. These flexibilities and practice expectations are premised on guidance from the U.S. Substance Abuse and Mental Health Services Administration³, and will be published in the upcoming **FY23**, **Quarter 2 Provider Manual for Community Behavioral Health Providers**, with an effective date contingent upon federal guidance regarding the termination of the federal COVID-19 Public Health Emergency (PHE) declaration. The PHE declaration has been extended multiple times over the past two years, and the DBHDD cannot predict whether there will be any future extensions. However, we are publishing this telemedicine content so that providers may proactively plan for service delivery post-PHE, and avoid the potential for future disruptions to their operations due to uncertainty. To ensure clarity, consistency, and administrative simplification, we will be focusing this content in a single designated area of the Provider Manual (Part II). The anticipated language is noted below and will be included in the revised Provider Manual (FY23, Quarter 2) when it is published to our website on September 1, 2022.

Thank you for all that you have done and continue to do, and for your continued commitment to the citizens of Georgia.

Footnotes

- 1 University of Georgia, Carl Vinson Institute for Government (2021). <u>DBHDD Telehealth Survey Report.</u>
- 2 This expansion will be contingent upon current and future federal allowances.
- 3 U.S. Department of Health and Human Services, Substance Abuse and Mental Health Services Administration (2021). <u>Telehealth for the Treatment of Serious Mental Illness and Substance Use Disorders.</u>
- Georgia Collaborative ASO
 Brian Dowd, Department of Community Health
 Lynnette Rhodes, Department of Community Health
 Rebecca Dugger, Department of Community Health

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Telemedicine and Telephonic Intervention Requirements for All Community-Based Behavioral Health Services

Provider Manual for Community Behavioral Health Providers

The below excerpt will be included in Part II, Section I of the Provider Manual.

Part II. Community Service Requirements for Behavioral Health Providers

Section I. Policies and Procedures

- 1. Guiding Principles
 - B. Access to individualized services.
 - ii. There are no barriers in accessing the services, supports, and treatment offered by the provider, including but not limited to:
 - 16. Telemedicine and telephonic interventions may be used as a means to deliver person-centered services, in accordance with the following:
 - a. Definitions:
 - i. "Telemedicine" is the use of medical information exchanged from one secured site to another, via electronic communications, to improve a patient's health. Electronic communication means the use of interactive telecommunications equipment that includes, at a minimum, audio and video equipment permitting two-way, real time interactive communication between the patient, and the physician or practitioner at the distant site.
 - 1. Originating Site: The site where individuals are being served via telemedicine (i.e. this may be at their homes, in schools, in other community-based settings, or at more traditional service sites).
 - 2. Distance Site: The site where the practitioner providing the professional service is located at the time the service is provided via a telecommunications system.
 - ii. "Telephonic" is the use of medical information exchanged between one individual and another, via an audio-only communication exchange made by telephone.
 - iii. "Face-to-Face" (FTF) language is found throughout the BH Provider Manual, and is herein redefined to mean either "inperson" or "via the use of telemedicine technology," based upon the provider's clinical judgment in accordance with the criteria set forth in item "g" below. However, "Face-to-Face" is never inclusive of telephonic intervention.
 - b. The telemedicine connection must ensure HIPAA compliance related to Privacy and Security (employing authentication, access controls and encryption to allow for patient/client confidentiality, integrity and availability of their data).
 - c. All individuals served via telemedicine (DBHDD state-funded and Medicaid FFS) must sign a consent form, a copy of which must be placed in each individual's health record. For Medicaid-covered

individuals, the Department of Community Health requires that: "The Telemedicine Member Consent Form for each individual is outlined in the Telemedicine Guidance Document and must be utilized." For individuals served using DBHDD state funds, providers may either use the DCH consent form, or create one containing the same information/components, as applicable.

- d. All individuals served via telephone (DBHDD state-funded and Medicaid FFS) must also sign a consent form, a copy of which must be placed in each individual's health record. Providers should either create a separate form containing the same applicable information/components as is utilized in their telemedicine consent form, or may combine the consents into a single form so long as consent to each modality (telemedicine vs. telephonic) is clearly delineated.
- e. Limits regarding telephonic service delivery may exist for certain services. Any such limits can be found in the Service Definition for the specific service in question (see Part I of this manual), and must be adhered to.
- f. Telephonic service delivery must adhere to the 2022 released guidance from the U.S. Department of Health and Human Services, Office for Civil Rights¹.
- g. The use of telemedicine or telephonic service delivery should never be driven by the practitioner's or agency's convenience or preference.

 Telemedicine and telephonic service delivery should only be deployed based on sound clinical judgement, and with documented consideration of the following:
 - i. The nature and complexity of the service, and of the particular service intervention(s) to be implemented;
 - ii. The individual's needs and preferences;
 - iii. The individual's current clinical presentation and life circumstances (e.g. symptom type and acuity, risk of harm, a significantly stressful and recent life event, etc.);
 - iv. The individual's access to, and comfort with technology;
 - v. The individual's ability to have private and confidential conversations/interactions with the provider;
 - vi. Safety of the individual's home environment or other environment where the individual is receiving services;
 - vii. The potential for viable strategies to address any of the above, as well as any other barriers that may exist.
 - viii. Frequent re-evaluations of telemedicine/telephonic service delivery in consideration of the above, and any other factors that may impact the feasibility of these service delivery modalities.
- h. To promote access, providers may use Telemedicine as a tool to provide direct interventions to individuals for whom English is not their first language. Examples of this include:
 - the use of one-to-one service intervention via Telemedicine, by connecting the individual to a practitioner who speaks the individual's language (i.e. rather than using an interpreter); and/or

- the use of an interpreter via Telemedicine (i.e. as a third party) to support the practitioner in delivering the identified service to an individual.
- i. Provider agencies must have a written policy that addresses all of the above sub-items listed under item 16. Telemedicine and telephonic interventions. This policy must address implementation plans/protocols, including internal staff training, documentation in the individual's health record (including the expected frequency of reevaluations regarding telemedicine/ telephonic modality appropriateness), self-evaluation measures, and internal record review procedures.

Footnotes:

1 US Department of Health and Human Services, Office for Civil Rights. (June 13, 2022). <u>Guidance on How the HIPAA Rules Permit Covered Health Care Providers and Health Plans to Use Remote Communication Technologies for Audio-Only Telehealth. https://www.hhs.gov/hipaa/for-professionals/privacy/guidance/hipaa-audio-telehealth/index.html</u>